

**Investigating Social Relationships, Depression and
Hopelessness in Older People**

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ABSTRACT

Aim: The aim of this study was to investigate differences between the two groups in relation to level of hopelessness, perceived social support, size of social networks and social relationships, in particular marital relationships. The investigator was interested in how an individual's functioning may impact on his or her social relationships and the effect of marital status on levels of depression and hopelessness.

Design and Method: A cross-sectional between groups design was utilized. Older people with a diagnosis of depression (aged 65 and over) were compared to a community control group of older people (aged 65 and over) who were not depressed. All participants completed questionnaires measuring mood, level of hopelessness, perceived social support and demographic variables such as marital status and size of social network.

Results: The main result was that older people who were depressed were satisfied with their level of social support. Group comparisons revealed that there was no difference in perceived social support despite older people who were not depressed having significantly larger social networks. However, higher levels of hopelessness were found in individuals who were not currently in a marital relationship. This finding has implications for clinicians working with older people with mental health difficulties.

Conclusions: Interpreted using a life-span perspective, the results suggests that older people may adapt to the ageing process by focusing on social support from a smaller set of ties which includes family and close friends. This highlights the complexity and multifaceted nature of social relationships as people grow older, regardless of whether they have or have not mental health difficulties. The study showed that levels of hopelessness were present in participants who were not depressed and the importance of social relationships for well-being in later-life.

CHAPTER 1: INTRODUCTION

1.1 Introduction and Overview

“Work is needed to ensure that the priority given to younger adult’s mental health is extended to include older adults; it is only then will we be able to ensure that all older people will be able to experience good mental health and well-being.”

(The Swedish National Institute of Public Health, 2006, p.5)

Demographics throughout the world are changing with the proportion of people over 60 years being the fastest growing age group in the world, with a rapid increase in those over the age of 80 (World Health Organisation, 2002). As a consequence, more and more psychotherapists will come into contact with older people who will therefore need to be aware of the emotional distress and specific needs of an ageing population (Laidlaw and Baikie, 2007). Therefore, identifying the factors which contribute to mental health issues in older people is an important area of research.

This thesis attempts to understand some of the factors which can contribute or protect older people from psychological distress, specifically the role social relationships have in predicting depression and hopelessness in older people. This thesis will initially discuss the research literature on demographic change and specific issues pertaining to older people such as successful ageing and ageism. It will then describe mental health issues in older people, with particular reference to depression and hopelessness. Finally, social relationships and social support in older people will be discussed. Underpinning the presented information will be the theory of socioemotional selectivity (Carstensen, 1992). The current study focuses on

individuals over the age of 65 who have/or do not have a current diagnosis of depression.

1.2 Changing demographics in society

We are living in an ageing society (Kinsella and Velkoff, 2001). Increased life expectancy has resulted in a rapid rise in the relative numbers of older people in societies across most parts of the world (United Nations, 2001). This has been due to two major factors; firstly, the reduction of infant mortality and childhood deaths due to better prenatal care, clean water, an increase in the food supply and the control of infectious diseases. Secondly the death rate of older people declining due to advances in science and medicine (Rowe and Kahn, 1998). In 2025, there will be approximately 1.2 billion people over the age of 60 worldwide (WHO, 2002), accounting for one third of the population in Europe (The Swedish National Institute of Public Health, 2006).

Meeting the needs of an ageing society is one of the main challenges that Scotland is facing at the beginning of the 21st century with 7 per cent of the population over the age of 75 taking up to 22 per cent of the NHS budget in Scotland (Wood and Bain, 2001). This provides a challenge not only for health professionals who work within older adult services, but also for other healthcare professionals who have had no training in working with older people but find themselves increasingly in contact with this population. As a result, psychosocial interventions will play a crucial role in the treatment of psychiatric disorders (Knight, 2004). As with an adult population,

the stigma associated with mental health disorders is dominant in our society (Scottish Executive, 2003). However, older people have the added experience of age discrimination or ageism which can have a detrimental effect on an individual's mental health (The Swedish National Institute of Public Health, 2006). This has been called 'double stigmatization' (Sartorius, 2003). In other words, due to mental illness and growing old, this creates a double stigma which can create difficulties in accessing healthcare and isolate an individual from their community (Lima, Levav, Jacobsson and Rutz, 2003).

This study took place in the Grampian region of Scotland, which has an estimated population of 542,100 with approximately 15 per cent of this population being over the age of 65. Wood and Bain (2001) estimate that this figure will increase to 24 per cent by the year 2016. However, projected population figures (NHS Grampian, 2004) estimate this increase to be attained by 2014, with an increased proportion of older people in rural areas. This suggests that there will be an increase in the number of older people presenting with mental health difficulties. Therefore, it is important to gain a better understanding of the issues pertaining to older people and factors which may contribute to or protect individuals from psychological distress.

1.3 Specific issues in ageing

1.3.1 Ageism

Ageism has been called "*the ultimate prejudice*" (Palmore, 2001, p.572) which involves the discrimination and stereotyping of older people. Ageism is a unique

form of prejudice due to the fact that all humans make the transition into different age group memberships as they grow older (Packer and Chasteen, 2006). Therefore, 'old age' is the only out-group which becomes an in-group for those who live long enough (Levy, 2003). Levy (2003) proposed that older people may be particularly vulnerable to negative stereotypes due to the fact that stereotypes associated with ageing are internalised some time before they are relevant to the individual's identity. This is based on the findings of research that children have internalised stereotypes of ageing and as individuals age the negative stereotypes appear to be continually reinforced. However, this is an area which Levy (2003) concludes requires further empirical research.

Stereotypes can have a powerful effect on the attitudes of others. Kite and Wagner (2002) reviewed the literature on ageism and found that older people are considered more negatively when compared with younger people. Stereotypical attitudes of older people tend to be the perception that they are depressed, lonely and in mental decline. Neikrug (2003) found that the media frequently portrays older people as helpless in light of social, medical and psychological problems and views old age as a 'curse'. As a consequence, this maintains society's image that later life is a time to be fearful of (Haught, Walls, Laney, Leavell and Stuzen, 1999). Unfortunately, ageist attitudes fail to consider that many older people live rewarding and productive lives in later life (Rowe and Kahn, 1998). Furthermore, many older people are free from major illness or psychological distress and thus age successfully (Clark, 2005). This has been the focus of research in the area of gerontology in recent years.

1.3.2 Successful ageing

Successful ageing has been proposed as one of the key research areas in recent years with its emphasis on helping to understand which factors leads to effective functioning in later life (for a recent review, please refer to Depp and Jeste, 2006). Rowe and Kahn (1998) proposed that successful ageing has been defined as the ability to maintain three key behaviours or characteristics. Successful ageing means different things to different people and although the three components are important, an individual does not have to have all three to age successfully. The three components are as follows;

- Low level of disease and disease related behaviour (maintaining healthy behaviours at the individual level and cope with physical change).
- High mental and physical functioning (deals with psychological losses: can be prevented and functional loss regained, encourages lifestyle change).
- Active engagement of life (ability to maintain psychological growth and potential; happier, more fulfilled lifestyles are healthier and promote successful ageing) (Rowe and Kahn, 1998).

There have been some debates over this model, namely its inability to take into account the role of social and environmental factors (Holstein and Minkler, 2003). Minkler (1990) highlighted that the way in which an individual interacts with their

environment is dependent on factors such as a sufficient income, good health care, good nutrition and a safe neighbourhood. In addition, successful ageing sets limits on how we age but does not expand on how the aforementioned factors may impact on one's inability to age successfully (Holstein and Minkler, 2003).

The World Health Organisation (WHO) developed an Active Ageing policy in 2002. The concept of active ageing was adopted by WHO in the late 1990's. This is similar to successful ageing but focuses not only on the individual's responsibilities but responsibilities of society to permit older people to contribute to society. They proposed that older people are active participants in an age-integrated society and as a result maintaining autonomy and independence should be a priority for individuals. Therefore, one could argue that the concept of active ageing and successful ageing is invaluable in improving people's quality of life as they age. However, one of the biggest arguments towards this programme is that it is better suited to younger older people and that the biggest challenges of ageing are felt most amongst the oldest old or "*4th agers*" (Baltes and Smith, 2003).

The idea of active ageing is based on the premise that one has autonomy and independence (WHO, 2002). Baltes and Smith (2003) propose that this concept is somewhat constrained in the oldest-old (individuals aged over 80 years). The authors propose that due to increased longevity, the literature now distinguishes between the third age (young-old) and the fourth age (oldest-old). Laidlaw and Baikie (2007) argue that the oldest-old face greater challenges and an increase in the complexity of difficulties they have to face. These difficulties include significant losses in cognitive

abilities, increased levels of frailty and multimorbidity and a large prevalence rate of dementia (Baltes and Smith, 2003).

Overall, the concepts of successful ageing and active ageing are crucial in helping to improve an individual's quality of life. However, as discussed this may be constrained in the oldest-old population. In addition, mental health disorders can significantly impede an individual's ability to age successfully. This will now be discussed generally, then more specifically on the topics of depression and hopelessness.

1.4 Mental health in older people

Recent documents have highlighted the priority of improving mental health and well-being in older people. The Scottish Executive's 2001 National Programme for Improving Mental Health and Well-being (Wood and Bain, 2001) highlighted that older adulthood can be a huge time of change which can be positive for some but also brings with it some negative changes such as reduced social contacts and increased social isolation. The document pointed out that the aim of society was to support older people in their ability to make a contribution to society and to maintain their links with family, friends and the wider community (Scottish Executive, 2003). More recently, a document produced by The Swedish National Institute of Public Health in 2006 highlighted the importance of promoting good mental health in later life. This document which was part of a Healthy Ageing project, in conjunction with European contributors, recorded and examined facts and evidence concerning health

promotion for people over fifty years of age. One of the issues the report highlighted was the need to strengthen the literature for mental health in later life.

1.5 Depression

1.5.1 Overview of depression

It is difficult to summarise the research on the topic of depression due to the vast quantity of literature published in this area. The majority of research is driven by the need to improve mental well-being for individuals with a depressive disorder. Policy makers and recent documents such as the National Institute for Clinical Excellence (NICE) Guideline Number 23 on Depression (2004) have brought to our awareness the economic burden associated with depression which has significantly increased over the last decade, with depression placing a huge burden on not only individuals and carers but also the healthcare system (NICE, 2004).

Before focusing on depression in older people, it is important to give a general overview of depression across the lifespan in order to highlight the complexities in presentation in later life.

Depression is one of the most common psychiatric disorders. It is estimated that each year 100 million people throughout the world develop a depressive illness (Gotlib, 1992). This has led to depression often being referred to as the “*common cold of psychiatry*” (Seligman, 1974). The World Health Organisation (WHO) has predicted that by 2020, depressive disorders, more than any other condition will have a

detrimental effect on individuals' quality of life. Indeed, depression is linked to a decline not only in well-being but in an individual's daily functioning (Beekman, Deeg, Van Tilburg, Smit, Hooijer and Van Tilberg, 1995).

Depression is marked by a cluster of symptoms which commonly are linked to mood and affect. In addition, behavioural and physical symptoms are typically present (NICE, 2004). There has been some debate in the published literature as to whether depression may be categorised as a psychiatric disorder or a cluster of symptoms (see George, 1993 for review). In general, two guidelines have been used widely by professionals in the diagnosis of depressive disorders, namely the ICD-10 Classification of Mental and Behavioural Disorders (WHO, 1992) and the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV) (APA, 1994).

The age of the first episode of a major depressive episode, on average, occurs when an individual is in their mid-twenties although some individuals can have their first episode in childhood or adolescence (Fava and Kendler, 2000). Kupfer (1991) found that at least 50 per cent of individuals will go on to have at least one further episode of major depression with an early onset of the first episode being related to vulnerability to further depressive episodes across the life span. This is supported in a study by the World Health Organisation (WHO, 2001) which found that 66 per cent of those who were diagnosed with depression were found to meet the criteria one year later with a mental health disorder, with the highest prevalence being for

depression with 50 per cent of the 66 per cent of all those who had been previously diagnosed with depression.

There are a number of models and theories of depression which have dominated the psychological literature over the past four decades; Behavioural Theory (Lewinsohn, 1974), Learned Helplessness Theory (Seligman, 1974), Cognitive Theory (Beck, Rush, Shaw and Emery, 1979), Social Theory (Brown and Harris, 1978) and a Biological Theory (see Blazer II and Hybels, 2005 for a recent review of the literature).

Depression is the most common mental health disorder in society which has costs, not only to the individual, but to families, friends and carers. There is also a huge economic burden that has put a strain on health care services. A variety of models and theories of depression have been proposed. In clinical practice, most clinicians will take into account cognitive, behavioural, social and biological factors when assessing for depression (Champion and Power, 2000). We will now look specifically at depression in older people.

1.5.2 Depression and older people

“Within our society for centuries a belief has been held that all of us who reach old age will inevitably have to suffer the unpleasantness it brings with it, up until that timely day when relief is brought by death. This view likens old age to the season of winter: cold, grey, dark days, lacking in vitality or even activity. It is no wonder that in assuming this view, becoming old has been equated with depression.”

(Blanchard, 1996, p.379)

Depression is the most frequent cause of psychological distress in older people, significantly reducing an individual's quality of life. In the last decade there has been a surge in the literature of depression in older people (Blazer, 2003).

Depression in older people consists of several different clinical presentations, including major and minor depressive disorders, bipolar affective disorder, depression associated with dementia and depressive episodes which have been termed reactive depression (Jorm, 1995). Specifically, related to later life, depression can occur in the context of neurological and medically related disorders with depression affecting those with chronic health conditions and cognitive impairment (Alexopoulos, 2005). This doctoral thesis will focus on individuals with a diagnosis of major or minor depression and will not focus on physical co morbidity or depression due to an organic aetiology. However, it is important to highlight that age related and disease related changes can add to the complexity of factors contributing to depression in later life.

Van den Berg, Oldehinkel, Bouheys, Brilman, Beekman and Ormel (2001) divided depression in older people into three distinct sub-groups:

- *Early-onset depression* is defined as the first lifetime episode of depression arising before 60 years of age. This was linked to long-standing psychobiological vulnerability to depression.

- *Late-onset depression* was defined as a first lifetime episode of depression commencing after the age of 60 years and was associated with severe stress
- *Late-onset with vascular risk factors* was defined as first lifetime episode of depression commencing after the age of 60 years and associated with organic illness.

Regardless of the aetiology or age of an individual, depression is a serious condition which is associated with a reduction in quality of life (Beekman et al, 1995) and an increased risk of suicide (Zweig and Hinrichsen, 1993). However, it may be extremely difficult to be precise with a definition of late-onset depression as it is possible that individuals may have experienced depression earlier in life but did not seek treatment (Blazer, 2003).

1.5.3 Prevalence of depression in older people

Major depression is the most common psychiatric disorder amongst the older people population (Blazer, 2006). However, rates of major depressive disorder amongst older people are lower than rates for younger people as suggested by data from the Epidemiological Catchment Area Study (Reiger, Boyd, Burke and Rae, 1988). However, Blazer (2003) highlights this figure may be due to secondary biases such as the underreporting of depressive symptoms.

A systematic review by Beekman, Copeland and Prince (1999) assessed the prevalence of late-life depression calculated an average prevalence rate of 13.5 per cent for clinical symptoms of depression. Data from the UK suggests that major

depressive disorder affects only a minority of older people, with Livingston, Hawkins, Graham, Blizard and Mann (1990) identifying an overall prevalence rate of 16 per cent for depressive symptoms in their inner London sample. Lindsay, Briggs and Murphy (1989) reported similar rates of depression in older people living in the community, with 13.5 per cent of their sample identified with mild to moderate depressive symptoms and 4.3 per cent identified with severe depressive symptoms. Nevertheless, age has a complex association with depression (George, 1993). It is reported that on average, older people report as many depressive symptoms as younger people but are less likely to receive a diagnosis of a depressive disorder (Laidlaw, Gallagher-Thompson and Siskin-Dick, 2003). As a comparison, it is interesting to note that the prevalence rates for depression within the adult population does not greatly differ from an older adult population. It is estimated that 15-20 per cent of adults having depressive symptomology (Gotlib, 1992). However, depression in older people is under-recognised and under-treated (Blazer, 2003).

There is evidence that sub-clinical levels of depression are more frequent than major depressive disorder amongst older people (Blazer, 2003). It is estimated that only 15 per cent of older people with depression receive treatment from primary or secondary care services (Blanchard, Waterreus and Mann, 1994). This was supported by research by Collins, Katona and Orell (1997) who investigated the attitudes of General Practitioners (GPs) in the UK in relation to the referral of older people with depression for psychological intervention. The authors found that whilst 93 per cent of GPs would consider referring an older person for psychological assessment, only

44 per cent of GPs have done so. Laidlaw et al. (2003) proposed that this is influenced by a number of factors such as;

- Ageist beliefs among professionals and other older people themselves may prevent people from receiving adequate treatment for depression.
- The notion of an “*understandability phenomenon*”, which was termed by Blanchard (1996) referring to the notion that depression is an inevitable part of growing older and is experienced as a normal part of ageing. In fact, healthy older people are at no greater risk from depression when compared to healthy, ‘normally functioning’ younger people. (Roberts, Kaplan., Shema and Strawbridge, 1997). In addition, there is no evidence that depression in later life is an inevitable part of the ageing process as the majority of older people do not show signs of depression (Blanchard, 1996).
- The notion of ‘masked depression’ or the underreporting of depressive symptoms by older people may be due to a misattribution that such symptoms are as a result of somatic complaints (Rothermund and Brandtstadter, 2003).

Unfortunately, these factors can contribute to depression in an older person being overlooked based on the assumption that depression is a natural consequence of the losses experienced by older people in terms of emotional attachments, physical independence and socioeconomic hardships (Laidlaw et al., 2003). In addition, many older people do not report psychological difficulties to their GP due to fear of the

stigma associated with mental health problems and feelings of shame (Lawrence, Murray, Banerjee, Turner, Sangha, Byng, Bhugra, Huxley, Tylee and Macdonald, 2006).

1.5.4 Risk factors for depression in older people

There are a number of risk factors which may result in a depressive illness. For some older people, depression may be a recurrence of past depressive episodes or it may be the first instance. As previously noted, there is also a link to depression being caused by neurological changes and may be a precursor of a dementia type illness (Karel and Hinrichsen, 2000). A study by Wragg and Jeste (2005) found that the prevalence rates for major depression in individuals with Alzheimer's disease were 17 per cent. In addition, depression can occur as a secondary condition in relation to a physical illness or disease. This is more prevalent in the older adult population who are more likely to have chronic health conditions such as arthritis, stroke and cardiovascular disease (Laidlaw et al. 2003). It is estimated that approximately 80 per cent of older people have at least one chronic health condition (LaRue, 1992). Although this is an area which will not be addressed in the presented study it remains to be an important factor in functional disability in later life.

Perhaps one of the most significant risk factors in the onset of a depressive disorder is an individual's past psychiatric history. Longitudinal studies have shown that 80 per cent of individuals experiencing a major depressive episode will have at least one more episode during their lifetime (Bosworth, Hays, George and Steffens, 2002).

Hinrichsen and Hernandez (1993) found that following recovery from a depressive episode, 19 per cent of the older people in their study had relapsed.

Finally, social support and social relationships, namely marital status has been shown to have an effect on an individual's psychological well-being and may be a risk factor in the development of a depressive disorder (Blazer II and Hybels, 2005). This literature will be expanded on further on in this chapter.

In summary, there appears to be multiple causes of depression in older people including biological, psychological and social causes (Blazer II and Hybels 2005). An increased prevalence of depression in older people has been associated with a variety of factors such as gender, age, history of depression, physical illness and interpersonal support amongst other factors. Such a number of factors suggest a complex aetiology to depression (Minardi and Blanchard, 2004). One of the characteristics of depression is hopelessness. This will now be discussed as it is an important component of depression and has been found to be predictive of future suicide behaviour (Beck, Brown and Steer, 1989). Therefore, it is an important factor to consider given that a negative preoccupation with the future is a necessary precursor for depression. The relevance to this study is that one's value for life is derived from the experience of the moment and not for the future (Carstensen, 1995). Therefore, it could be argued that hopelessness may impact one's ability to pursue social support and emotional regulation.

1.6 Hopelessness

Hopelessness has been defined as a “*set of beliefs that influences how a person perceives and interprets information as well as behaves in the world...hopeless thoughts can be chronic and persistent in certain individuals, activated in acute, specific situations in other individuals, or activated differentially in some individuals under certain conditions.*” (Uncapher, Gallagher-Thompson, Osgood and Bongar, 1998, p.63)

1.6.1 Theories of hopelessness

Abramson, Alloy and Metasky (1989) proposed a hopelessness theory of depression in which individuals who experience negative life events may in turn encounter a lack of social support which can lead to an increase in hopelessness resulting in what the authors termed “*hopelessness depression*”. More specifically, individuals who attribute negative life events to stable and global causes will mistakenly assume that they are fundamentally flawed leading to negative conclusions when they are faced with a stressful life event thus leading to hopelessness (Alloy, Abramson, Whitehouse, Hogan, Tashman, Steinberg, Rose and Donovan, 1999). However, the majority of studies for this theory have been conducted in adolescent and adult populations with no research with an older people population (Abela and Sarin, 2002).

Beck, Brown and Steer (1989) proposed that hopelessness is a crucial psychological feature of suicidal behaviour. Furthermore, cognitive models of depression specify how depressive thinking can negatively impact on interpersonal functioning (Beck et al. 1979). This can lead to relationships being perceived as less supportive. Beck, Kovacs and Weissman (1975) emphasised that hopelessness is a psychological state which is changeable. For example, during periods of psychological distress, levels of

hopelessness can increase in its potency. In addition, the intensity of hopelessness varies from person to person and varies within an individual across time (Young, Fogg, Scheftner, Fawcett, Akiskal and Maser, 1996). Perhaps one of the most important reasons hopelessness has been researched is its linkage to suicidal behaviour.

Associated with depression is hopelessness in which individuals have a negative view of the future. Hopelessness has been linked to suicide ideation and has shown to be predictive of future suicide completions (Brown, Beck, Grisham and Steer, 2000). A large number of studies have looked at the relationship between hopelessness and its association with suicidal ideation. Specifically, its importance in predicting, to some degree, future suicide attempts (Schlebesch and Wessels, 1988). In younger populations hopelessness has been found to be linked to suicidal ideation in a psychiatric population (Hill, Gallagher, Thompson and Ishida, 1988).

Hopelessness is associated with suicidal thoughts and has been studied both as cognitive or affective concept which is thought to have a pivotal role in the onset of depression (Uncapher et al., 1998). In a longitudinal study of 207 adult patients, hospitalised for suicidal ideation, Beck, Steer, Kovacs and Garrison (1985) found that high levels of hopelessness correctly predicted a high percentage of suicides following a 5-10 year follow-up. Beck and colleagues concluded that the degree of hopelessness may be a crucial indicator of long-term suicide risk in depressed patients. This has been supported by later researchers such as Niméus, Traskman-

Bendz and Alsen (1997) who found that hopelessness is a core psychological factor in suicidal ideation.

1.6.2 Hopelessness and older people

There is little published research, to the knowledge of the author, on the topic of hopelessness and older people. A study by Uncapher et al. (1998) investigated the role that hopelessness played in suicidal ideation. The study used older people recruited from in-patient wards excluding individuals with organic brain disease and bi-polar disorder. The authors found a significant relationship between hopelessness and suicidal ideation. They also discovered that older people who expressed negative expectations of the future were more likely to be suicidal. However, the findings of the study found that hopelessness did not predict suicidal ideation better than depression. Although this thesis does not investigate suicidal ideation directly, it is worth noting that people over the age of 65 years have the highest rates of completed suicide than any other age group (McIntosh, 1995; Alexopoulos, Bruce, Hull, Sirey, and Kakuma, 1999). The majority of older people who commit suicide consult their GPs within a few months of their death and almost a third during the week of their suicide (Collins, Katona and Orell, 1997). Statistics from Choose Life, a national strategy and action plan to prevent suicides in Scotland, showed that in 2005 there were 763 suicides with 191 of these occurring in those aged 55 years and above (Scottish Executive, 2007).

Uncapher et al., (1998) found that factors associated with suicidal ideation in the adult population such as insufficient social support and losses were more prevalent in

older people. McIntosh (1995) suggests that the breakdown of resources such as coping strategies and social support may occur when an individual is faced with several stressful life events which in turn may overwhelm an individual's ability to cope. In addition, suicide attempts and completions in older people were found to be correlated with mood disorders, in particular depressive illness. The authors point out that no individuals in their study who were suicidal were found to have high levels of hopelessness without the presence of depression thus suggesting a complex relationship between hopelessness and depression (Uncapher, et al, 1998).

1.7 Socioemotional Selectivity Theory (SST)

Social relationships have been identified as being an important resource for successful ageing (Lang and Carstensen, 2002). This topic will be discussed in detail further on in this chapter. However, it is important to point out that there has been a wealth of literature to support the idea that good social relationships are associated with better physical health and psychological well-being (Krause, 1987; Sarason, Sarason, Shearin and Pierce 1987; Dean, Kolody and Wood, 1990; Hagerty and Williams, 1999; Hays, Steffens, Flint, Bosworth and George, 2001).

Socioemotional Selectivity Theory (SST) is important in helping to understand that there are psychological processes which help to bring about changes in social preferences and goals as people age (Carstensen, 1995). The central premise of SST is that individuals select goals in accordance to whether the future is perceived as being open-ended or time-limited (Lang and Carstensen, 2002). If time is viewed as

being open-ended, individuals' goals are likely to pertain to the acquisition of knowledge or to seek out social contacts who may benefit them in the future (Carstensen, 1995). However, if time is perceived as limited, social relationships which are peripheral are abandoned in favour of maintaining the most intimate relationships within their social network (Shaw, Krause, Liang and Bennett, 2007).

As individuals age, there is a realisation that time is finite which may lead to them becoming more proactive in their engagement within their social world (Isaacowitz, 2005). Moreover, the theory predicts that older people interact with fewer people, maintaining close relationships but withdrawing from more peripheral relationships. As a consequence, an individual can increase gains and decrease risks within their social environment (Lansford, Sherman and Antonucci, 1998). In other words, an individual's social network may decrease in size but will engage in deepening close relationships leading to an increase in intimacy and mutuality (Potts, 1997).

As individuals age, there is a focus on emotional regulation leading to the choice of social partners being familiar to them (Carstensen, 1995). This difference in anticipated future is linked to developmental trends. More specifically, the knowledge trend begins during early life and declines over the life span as knowledge is accrued and the future becomes shorter. The emotional trend peaks in infancy and early childhood and decreases from late childhood and peaks again in later life when future goals become less important (Carstensen, Isaacowitz and Charles, 1999). This trend has also been noted in younger people when they are faced with conditions in which their time is limited, such as a terminal illness thus

suggesting that emotional salience is a crucial stage when people are nearing the end of their life and time is appraised as being limited (Carstensen, 1992). The model of SST and its life-span trajectory is represented schematically in Figure 1.

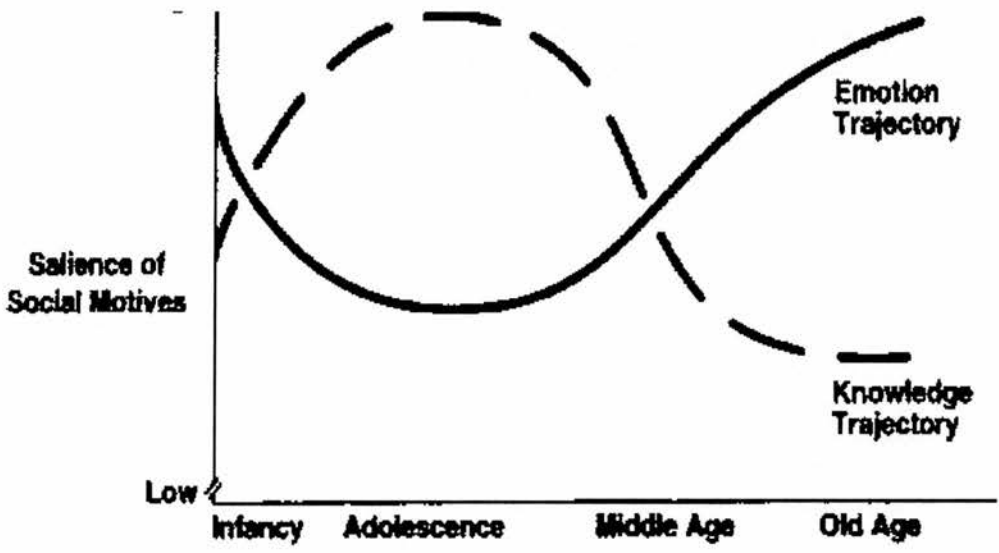


Figure 1 – Model of Socioemotional Selectivity Theory (replicated from Carstensen, Gross and Fung, 1997)

Isaacowitz (2005) points out that the ageing process is one of the strongest cues that time is limited and that the end is approaching. As melancholy as this sounds, SST proposes that it may lead individuals to become more optimistic as they are proactively controlling their social and emotional world (Carstensen et al. 1999).

SST has been supported by research (Carstensen, 1992; Carstensen and Lang, 1996; Carstensen et al., 1999; Adams, Sanders and Auth, 2004; Shaw et al. 2007). However, one of the criticisms of the research supporting this theory is the cross-

sectional design of the studies which makes it difficult to differentiate between true age effects and cohort differences in the sample (Shaw et al. 2007). In addition, the theory does not go into detail of psychological difficulties in later life. However, Carstensen et al. (1999) propose that individuals with depression focus on the fear of the future and therefore are distracted from the present and subsequent current emotional goals. Support for this theory has also pointed out that ageist stereotypes of older people as being lonely and isolated have been undermined by demonstrating that most older people continue to benefit from social relationships (Adams et al., 2003).

1.8 Social support and social relationships

1.8.1 Overview of social support and social networks

Social support is a broad construct and one in which definitions are complex. Essentially, social support can be defined as "*a multifactorial construct, including perception, structure of the social network, and tangible help and assistance.*" (Blazer II and Hybels, 2005, p.1247)

Social support refers to the provision of resources available to help an individual cope during periods of stress (Cohen, 2004). House and Kahn (1985) defined social support in terms of offering three types of resources:

- *Instrumental support* – providing material aid such as financial or practical help.
- *Informational support* – providing relevant information to help an individual cope with immediate difficulties such as advice or guidance.
- *Emotional support* – providing empathy and reassurance whilst allowing the person under stress to express their emotions.

There has been some debate in the literature as to whether social support acts as a buffer to psychological distress (Krause, 1987; Dean, Kolody and Wood, 1990; Hays, Steffens, Flint, Bosworth and George, 2001). Cohen and Willis (1985) proposed that social support acts as a protective factor when an individual experiences stressful life events. In particular the researchers propose that during such stressful times an individual's ability to cope will depend on their level of social support. Overall, the model proposes an interaction between stress and social support which can predict mental health. Essentially, an individual with a strong social support network is more likely to cope with life stressors than those with an inadequate social support network. More specifically, social support may lower the impact of stress by reducing the perceived significance of the difficulty or by offering a distraction from the problems (Cohen, 2004).

However, Russell and Cutrona (1991) have argued that there is little evidence for the model, suggesting that there are an equal number of studies which show any significant evidence for the stress-buffering hypothesis. They proposed that poor social support can lead both directly and indirectly to psychological distress. More

specifically, social support can increase the likelihood of minor stressful life events which can subsequently predict an episode of major depression (Russell and Cutrona, 1991). Krause (1987) proposes that whilst social support reduces the detrimental effects of life stressors, it does so by increasing self-esteem and it is this component which reduces the likelihood of depressive symptoms.

Indeed, social support has been proposed to have an effect on the onset and outcome of a depressive illness (Hagerty and Williams, 1999). Sarason et al. (1986) reported that an individual's social environment is not independent of the individual. Therefore, how they interpret and react to their social environment will result from what it provides. Sarason et al. (1986) proposed that individuals with poor social support will view their life as one of isolation. In most of the research on social relationships, social support has been found to have a strong association with emotional well-being (Acock and Hurlbert, 1993). Moreover, an individual's interpersonal circumstances which can determine his/her well-being (Lin, Dean and Ensel, 1986).

1.8.2 Social support and social networks in older people

"It is not the bad things that happen to us that doom us; it is the good people who happen to us at any age that facilitate enjoyable good health." (Vaillant, 2002, p.13)

"Social support is a coping resource that is obtained from interpersonal relationships and is used to alleviate the adverse psychological effects created by stress; it is believed to play a key role in older people by maintaining their health and decreasing their vulnerability to physical and mental illness." (Vanderhorst and McLaren, 2005, p.518)

It has been proposed that to understand protective factors for older people's mental health one should look at the protective factors including the interconnections older people have with their partners, other people and their environment (Vanderhorst and McLaren, 2005). Research has shown that the emotional component of these relationships have demonstrated that individuals who report poorer relationships will report a greater number of depressive symptoms (Travis, Lyness, Shields, King and Cox, 2004). More specifically, social factors are highly important as people grow older primarily as negative life events that older people experience frequently brings about a loss of social connectedness (Bisconti and Bergeman, 1999). For example, a loss of a spouse may lead to a reduction in social support as an individual's network may have been reliant on being in a couple. The emotional components of relationships will be discussed in detail later on in this chapter.

There has been some published evidence that has shown that social support plays an important role in the well-being of older people. More specifically, it has been shown to be positively correlated with psychological adjustment (Lang and Carstensen, 2002), decreasing vulnerability to physical and mental illness (Monahan and Hooker, 1997) and better psychological health (Hagerty, Williams, Coyne and Early, 1996).

Bisconti and Bergeman (1999) propose that the main reason that social support is of particular significance in older people is that they may experience an increase in significant life events such as retirement and loss of spouse. Life events such as retirement may result in a loss of a social network and may be accompanied by a reduction in income which may prevent an individual financially accessing activities in their community (Sluzki, 2000). There are also differences in gender in which men

have smaller social support networks than women and are more likely to rely on support from their wives (Lillard and Waite, 1995). In addition, older people may also experience disability or illness which may prevent them from participating in their usual activities with others. As a result of their disability or illness, they may lose their independence which may result in individuals having to go into residential care which means moving away from their community (Alpass and Neville, 2003). Such life events have a direct impact on the individual's social support network thus resulting in increasing the likelihood of a detrimental effect to one's well-being in terms of increasing the likelihood of individuals becoming depressed (Vanderhorst and McLaren 2005).

Therefore, from the published literature investigating social support, one may assume that by increasing an older person's social network individuals will experience greater levels of psychological well-being. In a large scale community sample, Seeman and Berkman (1988) found that the higher the availability of support from social ties, the increased likelihood of psychological well-being and better adjustment to age-related life events such as retirement and loss of a spouse. A study by Bisconti and Bergeman (1999) investigated the manner in which social support aided better health outcomes in older people. One of the factors they assessed was social network size. The study found that increasing an individual's social network may be detrimental as setting up social opportunities for them may erode their sense control resulting in a poorer psychological outcome (Bisconti and Bergeman, 1999). Indeed, Lam and Power (1991) argue that the quality of an individual's social

support is more imperative than the quantity of individuals within their social network. This is an idea which is supported by SST.

1.8.3 Perceived and actual social support

“Perceived social support is the subjective sense that people are available and willing to satisfy a range of roles that include emotional, friendship and tangible needs.” (Maher, Mora and Leventhal, 2006, p.450)

Research has found that perceived social support is a robust predictor of depression (Finch, Okun, Pool and Ruehlman, 1999) and the relationship between the two factors is strong, even when controlling for negative affectivity (Kahn, Hessling and Russell, 2003). Previous research has shown that older people who perceive their social support as unsatisfactory will experience higher levels of psychological distress than those older people who feel supported (Krause, 1987).

A study by Hays et al. (2001) found that subjective ratings of social support predicted depressive symptoms after a one year follow-up. A perceived lack of support has also been found to be associated with suicidal ideation in older people with a limited social network (Rowe, Conwell, Schulberg and Bruce, 2006). The authors argue that an older person's perception of his/her support network can act as a buffer against stressful life events and suicidal ideation. This finding was examined by Maher et al. (2006) who investigated the relationship between perceived social support and depression. They found that depressive cognitions were associated with

perceived levels of support influencing an individual's behaviour which in turn may serve to reinforce an individual's perception of social support.

Previous research has shown that social relationships, namely social support is predictive of depression (Vanderhorst and McLaren, 2005). There are several theories as to why this is the case. The main effect of depression is that it serves to erode an individual's perception of social support. Furthermore, individuals who have depression may actually receive less social support as they are likely to reject help when it is offered Maher et al. (2006) and tend to view themselves, others and the world around them in a negative way (Beck et al., 1979). Pierce, Sarason and Sarason (1991) argue that individuals have a set of expectations regarding their social relationships and this extends into expectations regarding the availability of social support in each of their significant relationships.

In summary, there are particular issues facing older people in relation to their social support. This life stage is regarded as a period of transition including retirement and death of a spouse to name but a few significant life events (Dean et al., 1990). In event of a close bereavement older people can find that they are separated from key sources of social support (Blanchard, 1996) leading to a decline in psychological health and well-being (Fry, 2001).

1.8.4 Social support as a predictive factor of depression and hopelessness

Social support has been extensively researched in relation to the outcome of major psychiatric disorders (George, Blazer, Hughes and Fowler, 1989). Generally, social

support has been identified as an important factor in the course and outcome of major psychological disorders with lower perceived social support amongst older adults found to predict greater frequency and severity of depressive episodes (Lynch, Mendelson, Robins, Ranga, Krishnan, George, Johnson and Blazer, 1999). During recent years a number of articles have investigated the association between social support and well-being. However, the relationship between depression and social support is a complex one (Travis et al., 2004). Therefore, there is not sufficient space to go into detail on this issue. However, it is important to note that research has shown that social support has a positive impact on an individual's well-being and some key papers on this topic will be discussed.

A recent study by Rowe, Conwell, Schulberg and Bruce (2006) investigated the association between social support and suicidal ideation in a community sample of older people. They found that the most significant factor associated with suicidal ideation was the perception of their social support network. The authors conclude that older people who believe they have adequate social support may find this to be a protective factor during significant life events as well as serving as a buffer against suicidal ideation.

Alpass and Neville (2003) argued against previous research that proposed depression was a response to functional impairment in older people. They suggested that although there is research which proposes depression as being a response to declining health and functional impairment, there is also other factors which may have a more prominent influence on the experience of depression in older people.

These authors investigated the relationship between loneliness and psychological well-being in relation to depression in older men. The study they conducted showed that social isolation was a significant predictor of the experience of depressive symptoms in older people. These findings are important in identifying other factors which may contribute to depression. However, one of the limitations of the study is that the results cannot be generalised across an older cohort since the population used in the research were men only.

A study by Travis et al. (2004) found that social support was predictive of depression in older people. However, Blazer and Hughes (1991) suggest that perhaps social support and psychological distress is “*caught up in a web of mutual influence*”

(p. 192) in which one is associated with the other which the authors describe as being an “*epiphenomenon*” (p.192). In other words, there may be an overlay between subjective social support and depression which may lead to methodological inadequacies within research investigating these two variables. However, there is a complex relationship between social support and depression and one in which there is no available evidence to resolve the uncertainty between the two variables (Blazer and Hughes, 1991). Therefore, it would appear that the two variables have a strong association. Poor social support has been found to be associated with an increase in suicidal ideation, even when individuals have a diagnosis of mild depression (Alexopoulos et al. 1999). Alexopoulos and colleagues argue that the relationship between social support and suicidal ideation is complex and may be mediated, in part, by depressive cognitions which may have an impact on the perception or accessibility of social support.

A longitudinal community based study by Turvey, Conwell, Jones, Phillips, Simonsick, Pearson and Wallace (2002) found that older people who did not become depressed or go on to commit suicide were more likely to have the presence of others to confide in and were active in the community. Furthermore, limited social support was found to be a factor in late-life suicide. This finding has been supported by a number of studies (Blazer and Hughes, 1991; Mireault and de Man, 1996; Vanderhorst and McLaren, 2005). A study by Hill et al. (1988) investigated the role hopelessness played in suicidal ideation. The study used older people with a diagnosis of depression and found that hopelessness was associated with factors unique to older people such as retirement and loss of a spouse. This perhaps indicates that social support and social relationships may act as a psychological buffer against emotional distress (Dykstra, 1995).

Therefore, it appears that social support should be considered as a critical factor when examining predictors of depression and hopelessness in older people. In the following section, it is important to focus on marital status and friendship as this may be an important factor in the availability of social support amongst older people (Umberson, Chen, House, Hopkins and Slaten, 1996).

1.8.5 Marital status

"The spousal relationship is unique, long-lasting and singularly important social relationship. Most people report turning to their spouse both to share an important, positive, pleasant or joyful event and to seek solace or support when facing a stressful situation." (Antonucci, Lansford and Akiyama, 2001, p.69)

The concept of marital status and psychological well-being has been extensively researched. A recent paper by Manzoli, Villari, Pirone and Boccia, (2007) carried out a systematic review and meta-analysis evaluating the association between marital situation and mortality in older adults. The authors found that in a meta-analysis of 53 published studies between 1995 and 2005, marriage was a significant predictor of a reduced mortality risk when compared to non-married older people. This finding was found in both men and women. Peters and Liefbroer (1997) propose that the benefit of marital status on well-being may be due to the presence of a partner to meet fundamental human needs and to provide resources. In addition, marriage provides companionship and decreases the likelihood that an individual may feel lonely (Vanderhorst and McLaren, 2005).

According to SST, marital relationships become more salient in later life and have a more powerful effect on an individual's well-being (Carstensen, 1992). Research has shown that marriages which have declined in midlife can become increasingly positive as people grow older (Carstensen, Gottman and Levenson 1993). A study by Carstensen et al. (1995) investigated the emotional situation of long-term marriages using 156 couples by comparing one middle-aged group and one older-people group. The study gave support for the idea that in older partnerships the outcome of conflict was less emotionally negative and more pleasant than with middle-aged couples.

Research has shown that individuals who are married can have a relationship which permits an ability to confide in and receive support from their spouse (Lillard and Waite, 1995). It has been hypothesised that this may act as a psychological buffer

against emotional distress which in turn reduces the likelihood of the development of a depressive illness (Dykstra, 1995). As previously discussed earlier in the chapter, social support from a spouse may become increasingly important as social networks decrease as people get older (Carstensen, 1992).

The issue of marital status and well-being in older people is an important one. It is a common assumption that old age is associated with isolation and loneliness (Essex and Nam, 1987). Indeed, older people are more likely than younger adults to experience the loss of a spouse through death (Antonucci et al, 2001). However, research has shown that not every older person living alone will experience social isolation. A study by Essex and Nam (1987) found that older people, especially women, are rarely social isolated with most having frequent contact with members of their family and friends.

Previous research has shown that older people who are currently married encounter less psychological difficulties than people who are single or have been widowed or divorced (Vanderhorst and McLaren, 2005). Nevertheless, several large scale studies have investigated the link between marital status and emotional well-being. A study by Hagedoorn, Van Ypren, Coyne, Van Jaarsveld, Ranchor, Van Sonderen and Sanderman (2006) examined the association between marital status and distress in people over the age of 65 years. As well as demographic and general health measures, individuals were asked to rate psychological distress. The authors found that married people were less distressed than single people. Furthermore, people who were widowed were more psychologically distressed than married people in the

immediate two years after the death of their spouse. However, the widowed people in the study appeared to adapt well to their single role. The authors conclude that marriage is not a protective factor against psychological distress and argue that although marriage may bring with it many benefits, it may also have a negative impact individuals felt dissatisfied in their marriage.

A large scale study by Peters and Liefbroer (1997) investigated partner history and well-being in 3,390 older people. Participants were asked a variety of questions based on topics including social networks and support. The authors found that there were high levels of loneliness amongst older people who were not currently involved in a relationship than those who were. They also noted that single older people who have never lived with a partner were less lonely and generally had higher levels of psychological well-being than those who were divorced or widowed. This apparent contradictory finding may be explained by those who have never lived with a partner having to rely on their own social skills and emphasising more focus on extending their social relationships (Peters and Liefbroer, 1997). This is somewhat of a paradox and the results of the study may have been confounded by gender differences.

Research has found that there are differences in males and females in terms of their reliance on social support (Umberson et al., 1996). In addition, Lillard and Waite (1995) found that women who have never married are different from those who are married, divorced or widowed. They argue that a large percentage of older women who have never married have spent most of their adulthood establishing patterns of

self-reliance and independence. Therefore, they have a higher availability of social contacts and networks.

Antonucci and colleagues (2001) investigated the association between emotional well-being and positive and negative aspects of social relationships in married older people with a best friend. The study found that compared with friendships, being married is more significantly related to well-being. A study by Chappell and Badger (1989) found that the combination of living alone, being unmarried and having no close friends was associated with higher levels of psychological distress.

1.8.6 Bereavement

Much of the research in the area of bereavement has been conducted in populations of older women. Lillard and Waite (1995) investigated marital status and loneliness in a sample of 356 older women. They found that the loss of a spouse is the most significant factor leading to loneliness. The authors argue that married older women who have invested heavily in the marital relationship will also have part of their social identity tied up in the relationship. Therefore, when the relationship is disrupted by events such as the death of a spouse, women will experience distress associated with losses of a partner and changes in relationships with others.

Essex and Nam (1987) suggest that to understand the change in this significant relationship, one should look at 'Symbolic Interaction Theory' (Blumer, 1969) which proposes that individuals are social creatures whose definitions of self are defined by the environment. As individuals age, they develop patterns of interaction which can

be disrupted. This results in a loss of the definition of the self and lead to distress and isolation. Therefore, older people who experience loneliness are likely to be those who have experienced a loss and disruption in the marital relationship through bereavement.

Research has found that gender differences are also apparent following widowhood. Lillard and Waite, (1995) found that men tended to yield their social support network from their spouse, therefore leaving them without adequate social support. Research studies have shown that there is a three-fold risk of suicide in widowed men compared to married men, with a higher risk of suicide in the year following the death of a spouse (Li, 1995). This was confirmed by a recent study by Harwood, Hawton, Hope, Harriss and Jacoby (2006) who found that the most frequent life events associated with suicide were interpersonal problems and bereavement.

Research by Wortman and Silver (1990) investigated depression levels in women following the loss of a spouse. They found that levels of depression were particularly elevated in the second year following the loss of a spouse. In addition, they proposed that in the first year following widowhood, individuals may experience an increase in social support which may act as a temporary buffer against depression. However, when the level of support returns to the level before the loss of a spouse, it may also result in deterioration in well-being. This finding was supported by Lopata (1980) who argued that when investigating disrupted marital relationships, one should look at a developmental perspective. Specifically, the more time elapsed since the marital

disruption, married women will, over time, set up new social outlets and routines to establish the sense of security they once had.

1.8.7 Friendships

In terms of research, there is little work on the role of friendships in later life. However, a limited number of studies have reported that friendships have been shown to be significantly associated to psychological well-being in older people (see Philipson, 1997 for a review of the literature). Most of the research to date has been conducted with women and has found that women's friendships tend to be person-orientated and is characterised by emotional support (Jerrome, 1981).

Friendship has been found to be particularly important throughout the life course (Antonucci et al. 2001). Early research by Brown and Harris (1978) found that having a close friend is crucial in the maintenance of good psychological well-being. Philipson (1997) concluded that friendship increases in significance as one gets older, specifically, friendship helps to maintain self-identity and moral. Jerrome (1984) reported that friendship has been found to be a protective factor in adjustment to life after bereavement as it provides a confidant relationship.

The literature suggests that there are gender differences between men and women. Firstly, women are more responsible for maintaining social connections with family and friends. Therefore, women who are unmarried may benefit from having a good social network, whereas unmarried men are more likely to be isolated in comparison to women (Lillard and Waite, 1995).

To sum up, previous research conducted with an older adult population has highlighted the association between social support, social relationships, and depression. However, much less has been researched in the area of interpersonal dimensions of depression in older adults (Hinrichsen and Emery, 2005). This is an important area of research since social support is particularly relevant for older people given that more common life events in this population, such as bereavement and retirement, may impact on their support system. The particular research aims and hypotheses of this study are detailed in the next section.

1.9 Research aims and hypotheses

1.9.1 Research aims

The aim of the study was to investigate the differences between the two groups in relation to levels of hopelessness, perceived social support, social network size and social relationships, specifically, marital status. To date, the majority of research has focused on community based samples of older adults as opposed to older adults with a diagnosis of depression. As far as the researcher is aware, hopelessness has not been investigated as a factor in social support within research studies conducted with older adults. Previous research has focused on social relationships in relation to depression but as far as the author is aware, there have been no published research studies investigating hopelessness and social relationships in older people. These variables which have been selected have so in relation to the aims and hypotheses of the study. However, the author is aware of the complex relationship between social

support and depression and tried to ensure that the measures do not coincide in their content.

1.9.2 Research hypotheses

- Hypothesis One - It is hypothesised that older people in the depressed group will report higher levels of hopelessness than those in the non-depressed group.
- Hypothesis Two - It is hypothesised that older people in the depressed group will have smaller support networks in comparison to older people in the non-depressed group.
- Hypothesis Three – It is hypothesised that older people in the depressed group will report lower perceived social support in comparison to older people in the non-depressed group.
- Hypothesis Four - It is hypothesised that older people in the depressed group are less likely to be married when compared to older people in the non-depressed group.

CHAPTER 2: METHODOLOGY

2.1 Design

This study adopted a cross-sectional independent group design with two groups. The first group comprised of older people who currently had a diagnosis of depression (who will now be referred to as the depressed group). The second group comprised of healthy older people who were not depressed (who will be now referred to as the non-depressed group). The aim of the study was to investigate the differences between the two groups in relation to levels of hopelessness, perceived social support, social network size and social relationships, specifically, marital status. All participants completed four self-report questionnaires in relation to the aforementioned variables.

2.2 Participants

2.2.1 Depressed group; older adult participants

This group comprised of individuals who currently had a diagnosis of major depression (not related to an underlying organic aetiology such as dementia). Individuals were recruited initially from the local NHS service within the Grampian region of Scotland, specifically Kildrummy Day Hospital in Royal Cornhill Hospital, Aberdeen. However, due to a low uptake of participants, the recruitment procedure was revised and individuals were recruited from an out-patient Clinical Psychology Service and the Community Psychiatric Nurse Service.

A total of 35 individuals were identified as suitable for the study, with 20 individuals agreeing to take part. The average age of participants in the depression group was 74 years with an age range of 65 to 82 years. In total, 13 females and 7 males participated in the study.

2.2.2 Non-depressed group; older adult participants

This group comprised of healthy older people who had no current diagnosis of depression. Individuals were recruited from a local activity centre for older people within the Aberdeen area. Prior to recruitment, the researcher met with the Activity Centre Manager and representatives of the committee (which comprised of older people who were members of the centre) to discuss the purpose and aims of the study.

A total of 33 were identified as suitable for the study, with 28 individuals agreeing to participate. The average age of participants in the non-depressed group was 73 years with an age range of 65 to 80 years. Two participants were excluded from the study as one was under the age of 65 years and the other was actively undergoing treatment for depression. In total, 22 females and 6 males participated in the study.

2.2.3 Participant inclusion and exclusion criteria

2.2.3.1 Participants in the depressed group were required to satisfy the following inclusion criteria:

- 2.2.3.1.1 Have a current diagnosis of Major Depressive Disorder using the ICD-10 diagnostic criteria
- 2.2.3.1.2 Be aged 65 years and over
- 2.2.3.1.3 Be able to give written consent

2.2.3.2 Participants in the depressed group were required to satisfy the following exclusion criteria:

- 2.2.3.2.1 Have recently been discharged from hospital
- 2.2.3.2.2 Have a diagnosis of dementia or organic impairment
- 2.2.3.2.3 Are actively suicidal
- 2.2.3.2.4 Have a depressive episode due to bi-polar disorder
- 2.2.3.2.5 Depressive episode is secondary to a physical illness
- 2.2.3.2.6 Are actively psychotic

2.2.3.3 Participants in the non-depressed group were required to satisfy the following inclusion criteria:

- 2.2.3.3.1 Be aged 65 years and over
- 2.2.3.3.2 Be able to give written consent

2.2.3.4 Participants in the non-depressed group were required to satisfy the following exclusion criteria:

- 2.2.3.4.1 Have a Geriatric Depression Scale score of 20 or above
- 2.2.3.4.2 Have a diagnosis of dementia or organic impairment
- 2.2.3.4.3 Currently receiving treatment for depression

2.3 Measures

All participants were invited to complete four self-report questionnaires on one occasion only: These were as follows;

- A Demographic Questionnaire
- The Significant Others Scale (SOS) (Power, Champion and Aris, 1988)
- The Geriatric Depression Scale (GDS) (Yesavage, Brink, Rose, Lum, Huang, Adey and Leirer, 1983)
- Beck Hopelessness Inventory (BHS) (Beck, Weissman, Lester and Trexler, 1974)

These measures will now described in more detail

2.3.1 Demographic Questionnaire (Appendix 1)

A specific demographic questionnaire was developed for this study in collaboration with thesis supervisors. Participants were invited to complete a questionnaire which asked for information regarding age, gender, level of education attained, marital

status, number of children, number of grandchildren, number of people in social network and a self-reported measure of how well they felt supported. The demographic questionnaire used in this study was guided by the literature on social support and points such as number of people in social network were incorporated into the questionnaire.

2.3.2 The Geriatric Depression Scale (GDS) (Yesavage et al., 1983) (Appendix 2)

The Geriatric Depression Scale (GDS) is a 30-item questionnaire which measures symptoms of depression. The measure is specifically for use with older people. The GDS was initially developed as a screening tool for detecting late-life depression but one of the main criticisms of the measure is that it does not have specific questions relating to thoughts of death and suicide (Pennix, Guralnik and Ferrucci, 1998). Nevertheless, the GDS has been shown to have robust internal consistency, test retest-reliability and good construct and criterion validity (Heisel and Flett, 2005; Montorio and Izal, 1996; Abraham, Wofford, Lichtenberg and Holroyd, 1994; Burke, Nitcher, Roccaforte and Wengel, 1992 and Abraham, 1991). In addition, the GDS does not assess the somatic symptoms of depression so scores are less likely to be biased by physical symptoms, specifically in those participants who have co-morbidity with physical health difficulties (Uncapher et al., 1998).

The GDS asks participants to rate a series of statements in how they have felt in the past week. Participants answer yes or no to 30 statements. An overall score, with a maximum of 30 is gained. A shorter version of the questionnaire was developed by Sheikh and Yesavage in 1986. This 15-item questionnaire (GDS-15) was found to be

useful to use with individuals who have physical illness or have a cognitive impairment due to organic brain disease such as dementia (Kurlowicz and Greenberg, 2007). As these factors are exclusion criterion for the presented study the 30-item format of the GDS will be used as a measure of depression. The scoring criteria for this version is shown in Table 2.1:

Table 2.1 Scoring criteria for The Geriatric Depression Scale (GDS)

Score	Interpretation
0-10	Normal Range
11-20	Mild
20-30	Severe

Yesavage et al.(1983)

2.3.3 Beck Hopelessness Scale (BHS) (Beck, Weissman, Lester and Trexler, 1974) (Appendix 3)

The Beck Hopelessness Scale (BHS) is a measure specifically designed to measure an individual’s negative attitudes regarding the future (Beck and Steer, 1987). The BHS is said to have good discriminate validity, content validity, internal consistency and test-retest reliability across a variety of populations (Aish and Wasserman, 2001). In addition, it is one of the most researched measures of hopelessness available and has shown to be sensitive in the prediction of future suicidal behaviour (Glanz, Haas and Sweeney, 1995). However, most of the research studies using the

BHS has been used within an adult population (Aish and Wasserman, 2001; Hill, et al., 1988).

The BHS has also been studied as an outcome measure with older people. Greene (1989) used the BHS on 400 adults in order to derive norms. It was found that mean ratings of the BHS was found to be 5.87 in participants who were aged over 65 years in comparison to a mean of 3.36 found in participants who were aged under 24 years. The author concluded that scores on the BHS increases as people get older.

Later research by Hill et al. (1988) investigated the BHS in relation to suicidal ideation, depression, health changes and perceptions of the future. They found that the BHS had a satisfactory level of internal consistency for use with older people. This study also revealed the BHS has three different factors which was determined from the items loading from a factor analysis of the scale. These were as follows;

- Positive outcomes for the future
- Issues of non-depressed and feelings of giving up
- Expectations of future events

The BHS comprises of 20 statements which the participant judges as true or false based on how their attitude has been in the past week. These statements assess the extent of negative expectancies about the immediate and long-term future (Beck and Steer, 1987). Each response is given a score of 0 or 1, with a total score of 20. An interpretation of the scores can be seen in Table 2.2. However, it is important to note

that these scores do not take into account the findings of the research on norms for the BHS by Greene (1989) and refers to the original BHS manual which states that the scale can be used to detect hopelessness in individuals aged 13 to 80 years of age. In addition, Beck and Steer (1987) found no significant correlation between the BHS and age. Therefore, the authors concluded that no age adjustment to the BHS scores was necessary. In addition, the British Psychological Society (2004) recommend the use of the BHS with an older population in order to measure hopelessness. Furthermore, as far as the researcher is aware there has been no further work conducted by Greene (1989) on norms for the BHS. It is important to point out that, to the author’s knowledge, there has been very little published research looking at hopelessness and older people. In the few studies that do investigate this topic, all have used the BHS and the author could find no paper which uses the norms derived by Greene (1989). Therefore, in order to retain reliability the original norms and scoring criteria derived by Beck and Steer (1987) will be used in this study.

Table 2.2 Scoring criteria for Beck Hopelessness Scale (BHS)

Score	Interpretation
0-3	Normal Range
4-8	Mild
9-14	Moderate
15-20	Severe

(Beck and Steer, 1974)

Beck and Steer (1987) emphasise that since the BHS score only indicated the overall severity regarding an individual's negative attitude about the future, other aspects of psychological functioning should be noted, specifically depression and suicidal ideation. In this respect, the BHS has been shown to be a useful measure to use with clinical populations, such as individuals with depression (Glanz et al., 1995). As a depressed group will be used in this study, the BHS is an appropriate measure to use.

2.3.4 Significant Others Scale - Short Form (SOS) (Power, Champion and Aris, 1988) (Appendix 4)

The Significant Other Scale (SOS) was developed in order to measure perceived social support and ideal social support in relation to an individual's relationships. This measure examines the quality of an individual's most important relationships and the perception of the support they receive. The SOS is a self-report measure which asks individuals to rate how they perceive their actual support as well as their perception of how ideal they would like their support to be from significant people within their social network. In this measure, social support is divided into two categories, 'emotional' and 'practical' support.

There are two forms of the SOS. The SOS (A) specifies seven individuals on the questionnaire, i.e. mother, father, brother, sister. On the SOS (B) participants decide on the individuals they wish to rate. Due to the nature of the population used in the study, the SOS (B) was chosen as a measure of perceived and ideal social support. This version also asks individuals to rate seven individuals. However, for

the purpose of this study, individuals were asked to rate a maximum of three relationships. Power et al. (1988) advocate the use of the short-form when other measures are being administered.

To complete the questionnaire, participants are asked to rate the perceived and ideal support in a number of relationships. This is done on a likert scale, with 1 indicating 'never gives this type of support' and 7 indicating 'always gives this type of support'. The discrepancy between actual and ideal level of support is calculated in order to give a measure of satisfaction of the perceived level of support.

The SOS has shown to have good reliability and validity (Power et al. 1988). In addition, it has been used with older people (Lam and Power, 1991) and has been shown to be able to discriminate between depressed groups from non-depressed groups (Power et al. 1988).

2.4 Ethical Approval

Ethical approval was given by the North of Scotland Research Ethics Committee on 31st January 2007 (Appendix 5). In addition, approval was given by the Grampian Research and Development Committee on 9th March 2007 (Appendix 5a). Initially, the researcher approached the Day Hospital Manager to access potential participants in the depressed group. However, due to a low uptake of potential participants, the Researcher then approached the North of Scotland Research Ethics Committee with a change to the recruitment procedure. As

a result a substantial amendment was required. This consisted of approaching other members of NHS staff to identify potential participants for the study. The approval form from the North of Scotland Research Ethics Committee was granted on 25th May 2007 (Appendix 5b).

2.5 Procedure

This section will describe the protocol for undertaking the study and aims to give sufficient information should this study be replicated in the future. Information included in this section will focus on the recruitment protocol and assessment tools which were adopted in the study.

2.5.1 Implementation of research protocol

2.5.1.1 Depressed group

Prior to recruitment, the researcher met with the Directorate Service Manager and wrote to four Consultant Psychiatrists to inform them of the study and to ask for their approval of the proposed recruitment procedure. In addition, the researcher with the Day Hospital Manager, two Clinical Psychologists and 5 Community Psychiatric Nurses (CPNs) to discuss the purpose and aims of the study. All eight members of NHS Grampian staff agreed to identify suitable participants for the study. Once identified, staff members gave individuals a study information leaflet (Appendix 6). Once individuals had given consent, potential participants details were passed onto the researcher.

Potential participants classed as suitable for inclusion in the study were given a letter inviting them to participate and an information sheet outlining the nature of the study (Appendix 7). A stipulation of the North of Scotland Research Ethics Committee was that this information was given to individuals by a health professional they already knew. Therefore, the information was given to individuals either by the Day Hospital Manager, Clinical Psychologist or Community Psychiatric Nurse. If individuals agreed to participate in the research their names were given to the researcher by either the aforementioned health professionals. As a stipulation of the Ethics Committee each individual's Consultant Psychiatrist had to confirm whether individuals were eligible to participate.

A time was then arranged to meet with participants on an individual basis on the day that they attended the Day Hospital or out-patient appointment. In the unlikely event they could not manage either, individuals were offered an appointment to be seen in their own home. The participant was then asked to complete four questionnaires. The one-off appointment took no longer than 30 minutes. Consent forms were obtained at this appointment. Once completed, participants were thanked for their participation and informed that if they wished a summary of the results of the study that they should contact the researcher at the end of August 2007.

All participants were informed that they had the right to withdraw at anytime or raise any concerns before, during or after participation. In addition, any individuals who become distressed as a result of completing the questionnaires were given support by the researcher.

2.5.1.2 Community non-depressed group

At the end of their activity class, potential participants were given a letter (Appendix 7a) inviting them to participate, an information sheet outlining the nature of the study and a consent form by the Activity Centre Manager. The Activity Centre Manager identified suitable participants for the study. Once individuals had given consent, potential participants' details were passed onto the researcher. A time, date and location was then arranged to meet with participants on an individual basis, coinciding with the end of an activity session. The participant was then asked to complete four questionnaires. The one-off appointment took no longer than 30 minutes. This appointment took place within the local activity centre. Consent forms were obtained at this appointment. Once completed, participants were thanked for their participation and informed that if they wished a summary of the results of the study they should contact the researcher at the end of August 2007.

All participants were informed that they had the right to withdraw at anytime or raise any concerns before, during or after participation. In addition, any individual who became distressed as a result of completing the questionnaires were given support by the researcher.

2.5.2 Potential Distress to Participants

It was not anticipated that the questionnaires would cause distress. However, it was possible that an individual may react in an unexpected way and become upset. If this were the case then the questionnaire completion would cease. In addition, the researcher would be present throughout questionnaire completion to offer support

should individuals become distressed. Furthermore, participants were given the researcher's contact details and it was made clear that they could contact her in the event of any issues arising from participating in the study.

2.5.3 Elevated Scores of Emotional Distress

In the event that an individual in the depressed group expressed suicidal ideation they will be informed that the researcher has a duty to inform the Day Hospital Manager, Clinical Psychologist, Community Psychiatric Nurse and/or Consultant in charge of their care. In the event that an individual in the non-depressed group disclosed depressive symptoms, suicidal ideation or if the questionnaires indicate significant levels of depression and they are not currently receiving help/advice from a health care professional regarding this they would be strongly advised to consult their GP. Individuals are informed of this protocol on the participant information sheet and on the consent form.

2.5.4 Confidentiality

All data was stored and retained by the researcher for five years in accordance with research guidelines. Data was stored according to NHS policies regarding confidentiality in a locked filing cabinet on NHS premises. All files were kept in a locked cabinet in the Department of Clinical Psychology (Older Adults Service). In addition all data was made anonymous at the initial recruitment stage (participants were assigned a number, this was used thereafter). Information was stored on the computer in this form. The list of identification numbers and participant consent forms was kept in a locked cabinet in the Department of Clinical Psychology (Older

Adults Service). Only the researcher and her two supervisors have access to the data. This information was made available on the information sheet outlining the nature of the study. For individuals in the depressed group, it was emphasised that all information was strictly confidential. However, should they express suicidal ideation or anything which may indicate that they are a risk to themselves or others, the researcher would have a duty of care to inform the individual's Consultant Psychiatrist as well as the Day Hospital Manager or Clinical Psychologist.

2.5.5 Informed Consent

Informed consent was obtained by the researcher. This was sought after potential participants had read the study information sheet and had given provisional verbal consent to be contacted by the researcher. Prior to participation individuals were given the opportunity to have any questions regarding the research answered. Potential participants were given a maximum of two weeks to decide whether they wanted to participate in the study. Throughout the recruitment and participation period, individuals were informed that they could withdraw at anytime without giving a reason. In addition, it was emphasised that withdrawing from the study would not effect their treatment. All potential participants were asked to sign a consent form prior to participation (Appendix 8 & 8a).

2.6 Sample Size Estimation

Cohen (1992) tables were used to estimate the required N, with $\alpha = 0.05$, power $= 0.8$ and a large effect size. The sample size calculation estimated that to achieve a

large effect size 26 participants were required in each group. This calculation was confirmed by nQuery advisor ® Version 6.01 (2006).

2.7 Approaches to Analysis

Data was analysed using SPSS for Windows (Version 14). Prior to formal statistical analysis of the data the demographic characteristics were explored. In order to test whether the data was normally distributed the Kolmogorov-Smirnov and Shapiro-Wilkes tests were utilized. These tests suggested that the data was not normally distributed, indicating the non parametric Mann Whitney U test was an appropriate statistic for between group differences. All comparisons compared the older people in the depressed group with older people in the non-depressed group. The analysis of data was directed by the research aims and research questions.

CHAPTER 3: RESULTS

The strategy for analysis of the data collected will be presented initially, followed by an evaluation of the descriptive characteristics of the sample. Following on from these initial investigations, the data will be examined in detail in relation to the main hypotheses.

3.1 Analytical strategy

The purpose of this study is to compare older people who have a diagnosis of major depression and older people who do not have a diagnosis of depression in relation to levels of hopelessness, social networks perceived social support and marital status. All analyses and testing of the individual hypotheses was undertaken by comparing the two groups.

In order to analyse the differences between the groups, the independent t-test was considered. However, the independent t-test can only be used if the data does not significantly deviate from the normal distribution (Field, 2005). Before carrying out these tests it was necessary to undertake some exploratory data analysis in order to find any outliers which could potentially skew the data. Therefore, the data was checked by using the Kolmogorov-Smirnov and the Shapiro-Wilkes tests of normality. These tests found that the assumption of normality had been violated. As a result, the non-parametric counterpart of the independent t-test, the Mann-Whitney test will be employed unless otherwise specified.

When considering t-tests it is also important to take into account homogeneity of variance. In other words, the variance of a variable is stable at all levels of another variable (Field, 2005). Kinnear and Gray (2000) report that when there are equal numbers in each group a breach of this assumption is considered not too harsh. As there are less participants in the non-depressed group than there is in the depressed group Levene's test for equality of variances was undertaken as a test for homogeneity of variance. Provided that Levene's test is not significant ($p > 0.05$) the variance can be assumed to be homogenous. However, if the test is significant ($p < 0.05$) then the homogeneity of variance has been violated. Unless it is stated in this section, the assumption for homogeneity of variance has been met. All tests will be two-tailed unless otherwise stated.

3.2 Sample characteristics

3.2.1 Whole sample participants

A total of sixty eight people over the age of 65 were invited to take part in the study. Forty eight individuals agreed to participate, giving a response rate of 70 per cent. A total of 35 females and 13 males took part in the study. However, a lower response rate was found in the depressed group with 42 per cent individuals approached declining to take part in the study.

3.2.2 Depressed group

This group comprised of individuals who had a current diagnosis of depression and will now be referred to as the depressed group. An individual's diagnosis of depression had already been given by the Consultant Psychiatrist. In order to

diagnose an individual with depression the Consultant Psychiatrists used the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (1994) in addition to their own clinical judgment. Thirty five individuals over the age of 65 who had a current diagnosis of major depressive disorder were invited to take part in the study. Twenty individuals agreed to participate, giving a response rate of 57 per cent.

3.2.3 Non-depressed group

This group comprised of individuals who were not depressed and were recruited from a community sample. This group will now be referred to as the non-depressed group. Individuals within this sample were not screened for mental health problems. However, suitability for their involvement in the study was determined by individual's self-report that they were not currently depressed. Thirty three individuals over the age of 65 who were not currently depressed were invited to take part in the study. Thirty individuals agreed to participate, giving a response rate of 90 per cent. However, two individuals were excluded as they did not meet the inclusion criteria, giving a total of twenty eight participants in this group.

3.3 Demographic characteristics

3.3.1 Depressed group

In this group of twenty older people, there were thirteen females (65 per cent) and seven males (35 per cent). The mean age of this group was 74 years (SD, 5.31; range 65-80). The median age of the group was 74.5 and the modal age was 69. In terms of differentiating between the 'third' and 'fourth age' (Baltes and Smith, 2003) the distinction will be made using Neugarten's (1974) criteria age ranges for 'young

old' and 'old old' participants in the study. In this group a total of 10 older people (50 per cent) were in the young old category (between the ages of sixty five and seventy four) and 10 older people (50 per cent) were within the old-old category (over the age of seventy five).

3.3.2 Non-depressed group

In this group of twenty eight older people, there were twenty two females (78 per cent) and six males (22 per cent). The mean age of this group was 73 years (SD, 4.05; range 65-82). The median age of the group was 74 and the modal age was 71. In this group a total of 17 older people (60.7 per cent) were in the young old category (between the ages of sixty five and seventy four) and 11 older people (39.3 per cent) were within the old old category (over the age of seventy five).

3.3.3 Group comparison for key variables

Correlations between the key variables were undertaken to ascertain whether a relationship exists. A scatterplot was used to identify outliers and the Spearman's rho Correlation Coefficient test was used accordingly to analyse the relationship between variables. As the main variable was group (either depressed or non depressed), this was compared with the other key variables (age, gender, marital status, GDS score, BHS score, social network size and self reporting of social support). As is shown in Table 3.1 significant positive correlations were found between group and marital status ($\rho = .019$, $p < 0.05$, two tailed), GDS scores ($\rho = .000$, $p < 0.01$, two tailed), BHS scores ($\rho = .000$, $p < 0.01$, two tailed) and size of social networks ($\rho = .000$, $p < 0.01$, two tailed).

Table 3.1 Spearman's rho Correlation Coefficients for group (depressed vs non depressed) with key variables

	Marital Status	GDS	BHS	Size of social network	Adequacy of social support
Group	0.019**	.000*	.000*	.000*	.087

* Correlation is significant at $p < 0.01$ level

** Correlation is significant at $p < 0.05$ level

3.3.3 Group comparison for demographic characteristics

As shown in the mean values in Table 3.2 there was no significant difference in age between older people in the depressed group and in the non-depressed groups ($t(46) = 0.792$; $p = 0.432$). There was no significant associations between older people in the depressed group and older people in the non-depressed group in relation to Neugarten's age bands ($\chi^2 (1) = 3.99$; $p = 0.566$), gender ($\chi^2 (1) = 1.829$; $p = 0.198$), or level of education ($\chi^2 (1) = 4.89$; $p = 0.34$). Analysis also revealed a difference in relation to marital status between the two groups with a higher percentage of the non-depressed group currently in a marital relationship ($\chi^2 (3) = 8.466$, $p = 0.037$). This data is summarised in Table 3.3.

Table 3.2 Mean age of participants by group (depressed or non-depressed)

Demographic variable	Depressed group (n = 20)		Non-depressed group (n = 28)	
	Mean	SD	Mean	SD
Age	75	6.4	66.9	11.3

Table 3.3 Demographic characteristics of participants by group (depressed or non-depressed)

Demographic variable	Depressed group (n = 20)		Non-depressed group (n = 28)		Statistic Summary	
	N	%	N	%	χ^2	p-value
Age category					0.566	p > 0.05
• Young old (65-74)	10	50	17	60.7		
• Old old (75+)	10	50	12	39.3		
Gender					0.311	p > 0.05
• Male	7	35	6	22		
• Female	13	65	22	78		
Marital status					0.036	p < 0.05
• Married	4	20	15	53.6		
• Widowed	9	45	10	35.7		
• Divorced	4	20	3	10.7		
• Single	3	15	0	0		
Education					0.63	p > 0.05
• High school	20	100	22	78.5		
• Higher/Further education	0	0	6	21.5		

3.4 Social networks of participants

3.4.1 Depressed group

As seen from Table 3.2, 25 per cent of participants rated themselves as having less than three people that they see on a weekly basis while 50 per cent had between 3-6 people that they see on a weekly basis and 25 per cent of participants saw between 6-10 people that they see on a weekly basis. The mean size of network for the group was 5 (SD, 2.30; range 2-10).

3.4.2 Non-depressed group

As seen from Table 3.2, 7 per cent of participants rated themselves as seeing 3-6 people that they see on a weekly basis while 33 per cent had between 7-10 people that they see on a weekly basis. 60 per cent of participants had 10 or more people that they see on a weekly basis. No participant saw less than three people on a weekly basis. The mean size of network for the group was 11 (SD, 4.38; range 5-20).

3.5 Social support of participants

3.5.1 Depressed group

As seen from Table 3.2, 45 per cent of participants rated themselves as having very good levels of social support while 35 per cent rated their level of social support as good, 15 per cent as adequate and 5 per cent as very poor. No participant rated their level of social support as being poor. An individual's level of social support was determined using a self report question on the demographic questionnaire and not from a formal measure.

3.5.2 Non-depressed group

As seen from Table 3.2, 64 per cent of participants rated themselves as having very good levels of social support while 29 per cent rated their level of social support as good and 7 per cent as adequate. No participant rated their level of social support as being poor or very poor. An individual's level of social support was determined using a self report question on the demographic questionnaire and not from a formal measure.

Table 3.4 Information about social networks, social support and social relationships by group (depressed and non-depressed)

	Depressed group (n = 20)		Non-depressed group (n = 28)	
	N	%	N	%
Size of social network				
	5	25	0	0
• Less than 2	10	50	2	7
• 3-6	5	25	9	33
• 7-10	0	0	17	60 *
• More than 10				
Adequacy of social support				
• Very good	9	45	18	64
• Good	7	35	8	29
• Adequate	3	15	2	7
• Poor	0	0	0	0
• Very poor	1	5	0	0
Number of children				
• Less than 2	10	50	16	57
• 3-6	10	50	12	43
• 7-10	0	0	0	0
Number of grandchildren				
• Less than 2	9	45	14	50
• 3-6	6	30	11	40
• 7-10	3	15	2	7
• More than 10	2	10	1	3

- Correlation is significant at $p < 0.01$ level

3.5.3 Comparison of the depressed group and non-depressed group

A significant difference was found between groups in relation to size of social networks (($U = 47.500$; $p = <0.001$)) with older people in the depressed group reporting smaller network sizes in comparison to older people in the non-depressed

group. No significant difference was found between older people in the depressed group and older people in the non-depressed group on the self-reporting of adequacy of social support ($U = 90.50$; $p = 0.530$). No significant difference was found between groups in terms of number of children ($U = 275.000$; $p = 0.915$) and number of grandchildren ($U = 273.500$; $p = 0.891$). This data is summarised in Table 3.4.

3.5.3.1 Within-group comparison

Due to fewer married people in the depressed group compared to the non-depressed group, the groups were divided into married and not currently married within each group. Social network was compared in these two groups and no significant difference was found between marital status and social network size within the depressed group ($U = 22.500$; $p = 0.360$) or the non-depressed group ($U = 68.00$; $p = 0.384$).

3.6 Measures of depression and hopelessness

3.6.1 Mood status of depressed group

3.6.1.1 Depression status

On the Geriatric Depression Scale (GDS) 70 per cent of participants scored within the mild range for depression and 30 per cent scored within the severe range for depression. The mean score was 16.80 (SD; 6.178).

3.6.1.2 Hopelessness status

On the Beck Hopelessness Scale, 35 per cent of participants scored within the normal range while 25 per cent scored within the mild range for hopelessness, 20 per cent

scored within the moderate range and 20 per cent scored within the severe range for hopelessness.

3.6.2 Mood status of non-depressed group

3.6.2.1 Depression status

On the Geriatric Depression Scale (GDS), 100 per cent of participants scored within the non-depressed range. The mean score was 1.82 (SD; 2.091). No participants scored within the mid or severe range for depression. This can be seen in Table 3.5.

3.6.2.2 Hopelessness status

On the Beck Hopelessness Scale (BHS), 71.4 per cent of participants scored within the normal range while 28.6 per cent scored within the mild range for hopelessness. No participant in this group scored within the moderate range or severe range for hopelessness. This data for both groups is summarised in Table 3.5.

Table 3.5 Scores of depression and hopelessness by group (depressed or non-depressed)

Score	Depressed group (n = 20)		Non-depressed group (n = 28)	
	N	%	N	%
Geriatric Depression Scale (GDS)				
• 0-10 (not depressed)	0	0	28	100 *
• 11-20 (mild depression)	14	70	0	0
• 21-30 (severe depression)	6	30	0	0
Beck Hopelessness Scale				
• 0-3 (normal)	7	35	20	71.4**
• 4-8 (mild)	4	25	8	28.6
• 9-14 (moderate)	4	25	0	0
• 14-20(severe)	4	20	0	0

* Correlation is significant at $p < 0.01$ level

** Correlation is significant at $p < 0.05$ level

3.6.2.3 Comparison of the depressed group and non-depressed group

Depression was measured using the Geriatric Depression Scale (GDS) (Yesavage, Brink, Lum, Huang and Adey, 1983). The measure provides a score which can be compared to ranges of severity of depressive symptoms. The data is summarised in Table 3.4. There was a significant difference between older people in the non-depressed group and older people in the depressed group in relation to levels of depression. Older people in the depressed group had higher levels of depression in comparison to the non-depressed group ($U = 1.500$; $p = <0.001$). In addition, a significant difference was found between older people in the non-depressed group and older people in the depressed group and scores of depression ($U = 104.500$; $p = < 0.001$). This data is summarised in Table 3.6.

Table 3.6 Mann Whitney comparison of the depressed group and non-depressed group in relation to depression scores on the GDS

Measure	Depressed group (n = 20)	Non-depressed group (n = 28)	Statistical Summary	
Geriatric Depression Scale (GDS)	Median 16.00	Median 1.00	U 1.500	p-value <0.001

3.7 Testing of hypotheses

3.7.1 Test of Hypothesis One

It is hypothesised that older people in the depressed group will report higher levels of hopelessness than those in the non-depressed group.

Hopelessness was measured using the Beck Hopelessness Scale (BHS) (Beck, Weissman, Lester and Trexler, 1974). The measure provides three different factors which look at positive outcomes for the future, issues of non-depressed and feelings of giving up and expectations of future events. The data is summarised in Table 3.7.

Table 3.7 Mann-Whitney comparison of the depressed group and non-depressed group in relation to hopelessness scores on the BHS

Measure	Depressed group (n = 20)	Non-depressed group (n = 28)	Statistical Summary	
Beck Hopelessness Scale (BHS)	Median 7.61	Median 2.00	U 104.500	p-value <0.001

3.7.1.2 Comparison of depressed group and non-depressed group

There was a significant difference between older people in the depressed group and older people in the non-depressed group in relation to levels of hopelessness. The result was achieved by using the Mann-Whitney test as the data for older people in the depressed group deviated from a normal distribution. Older people in the depressed group had higher levels of hopelessness in comparison to the non-depressed group (U = 104.500; p = < 0.001). Therefore the hypothesis was supported.

3.7.2 Test of Hypothesis Two

It is hypothesised that older people in the depressed group will have smaller support networks in comparison to older people in the depressed group.

Social network size was measured using a self-report estimation as part of the demographic questionnaire which used a single question asking participants to report their network size. Table 3.3 details the percentages for both the non-depressed and depressed group. Older people in the non-depressed non-depressed group reported a larger social network in comparison to older people in the depressed non-depressed group (U = 47.500; p = >0.001). The data is summarised in Table 3.8.

Table 3.8 Mann-Whitney comparison of the depressed group and non-depressed group in relation to social network size

Measure	Depressed group (n = 20)	Non-depressed group (n = 28)	Statistical summary	
	Median	Median	U	p-value
Size of social network	4.50	10.00	47.500	<0.001

3.7.2.1 Comparison of depressed group and non-depressed group

There was a significant difference between older people in the depressed group and older people in the non-depressed group in relation to size of social network. The result was achieved by using the Mann-Whitney test as the data for older people in the depressed group deviated from a normal distribution. Older people in the depressed group had smaller social networks in comparison to the non-depressed group ($U = 47.500$, $p = >0.001$). Therefore the hypothesis was supported.

3.7.3 Test of Hypothesis Three

It is hypothesised that older people in the depressed group will report lower perceived social support in comparison to older people in the non-depressed group

Social support was assessed for each group by administering the Significant Others Scale (Power, Champion and Aris, 1988). The measure produces scores on actual social support and ideal social support for both emotional and practical support. The discrepancy between these scores is calculated and allows the researcher to establish how satisfied individuals are with the support they receive and whether they ideally would wish more or less support. Participants from the depressed group and non-depressed group were compared in relation to perceived and ideal social support.

The results were achieved by using the non-parametric Mann-Whitney U tests. This was necessary as the data for older people in the depressed group deviated from the normal distribution for actual emotional support ($K-S(20) = 0.382$, $p = 0.000$, $S-W(20) = 0.756$, $p = 0.000$), ideal emotional support ($K-S(20) = 0.292$, $p = 0.000$, $S-$

W(20) = 0.701, p = 0.000) and the discrepancy between the two scores (K-S(20) = 0.520, p = 0.000, S-W(20) = 0.354, p = 0.000). These deviations from normality were tested using the Kolmogorov-Smirnov and Shapiro-Wilk tests of normality.

Table 3.9 Mann-Whitney comparison between depressed group and non-depressed group in relation to perceived social support

<i>Significant Others Scale</i>	Depressed group (n=20)		Non-depressed group (n=28)		Statistical summary
<i>Type of support</i>	<i>Median</i>	<i>Range</i>	<i>Median</i>	<i>Range</i>	<i>Significance level</i>
Actual emotional support	5.95	5.00	6.68	3.00	p = 0.248
Ideal emotional support	6.15	5.00	6.60	2.00	p = 0.291
Discrepancy	0.15	2.00	0.14	1.00	p = 0.505
Actual practical support	5.55	4.00	5.78	4.00	p = 0.391
Ideal practical support	5.90	4.00	6.03	4.00	p = 0.929
Discrepancy	0.40	2.00	0.17	2.00	p = 0.680

As detailed in table 3.9 there is no significant difference when comparing older people from the non-depressed and depressed group in terms of actual emotional support (U = 231.000, p = 0.248), ideal emotional support (U = 236.500, p = 0.291) or the discrepancy between these two scores (U = 260.500, p = 0.505). In addition no significant difference between groups was found in terms of actual practical support (U = 240.500, p = 0.391), ideal practical support (U = 276.000, p = 0.929) or the discrepancy between these two scores (U = 214.000, p = 0.068). Therefore, the hypothesis was not supported.

3.7.4 Test of Hypothesis Four

It is hypothesized that older people in the depressed group are less likely to be married when compared to older people in the non-depressed group.

Marital status was measured using a self-report question as part of the demographic questionnaire which asked participants to report whether they were married, widowed, divorced or single. A higher number of older people in the non-depressed group reported being in a current marital relationship in comparison to older people in the depressed group. Chi square analysis showed a significant association between group and marital status ($\chi^2(3) = 8.466, p = 0.037$). In addition a chi-square (Fisher's Exact Tests) was utilised to partial out any effect of the baseline difference between the groups ($\chi^2(3) = 8.062, p = 0.035$).

3.8 Summary of Findings

To sum up, the data revealed that there were differences between the depressed and non-depressed group for some of the variables which were investigated. The findings can be summarised as follows:

- Older people in the depressed group had higher levels of hopelessness when compared to those in the non-depressed group.
- Older people in the depressed group reported smaller social networks when compared to those in the non-depressed group.
- No difference was found when comparing the groups for perceived support. No discrepancy was found between actual and ideal support for both emotional and practical support.
- Older people in the depressed group were less likely to be in a marital relationship when compared to those in the non-depressed group.

CHAPTER 4: DISCUSSION

The aim of the this study was to investigate whether there were any differences between older people who were depressed and older people who were not depressed in terms of hopelessness and social relationships, with a particular emphasis on social support, social networks and marital status. The findings of this study and its theoretical and clinical implications will now be discussed. The current published literature on these topics will also be examined. Underpinning the findings will be the link to Socioemotional Selectivity Theory (SST) and whether this study gives any support to this theory.

4.1 Hypothesis One

The hypotheses that older people in the depressed group will have higher scores for hopelessness in comparison to older people in the non-depressed group was supported. The data suggested that older people who have higher levels of depression have associated high levels of hopelessness. The finding that older people in the depressed group had higher rates of depression was consistent with individuals' diagnosis of a major depressive episode. However, in relation to hopelessness, 35 per cent of older people in the depressed group scored within the 'normal range' on the hopelessness scale. In addition, it was observed that 28 per cent of older people in the non-depressed group were in the mild range for hopelessness in the absence of any reported depressive symptoms.

A possible explanation for the finding that individuals who are not depressed show levels of hopelessness, may be due to the activation of a hopelessness schema (Young et al., 1996). Research by Weishaar and Beck (1992) found that hopeless cognitions can be continual in some individuals or triggered in acute specific situations in other people. This has led to the debate as to whether hopelessness is viewed as a 'trait' or a 'state of mind' (Glanz et al., 1995). This suggests that hopelessness is an active construct which can fluctuate from person to person and within a single person across a period of time (Young et al. 1996).

A further explanation to the findings of this study may be that hopelessness in non-depressed older people is related to an increasing awareness that time is limited. In other words, they may present as being more hopeless but have a realistic awareness of time (Uncapher et al, 1998). This idea would fit with theory SST. To summarise, SST proposes that the perception of time is vital in the pursuit of social goals. When time is perceived as open-ended, knowledge-related goals take precedence. However, if time is perceived as limited, emotional goals become the priority. In older people, time is perceived as limited which results in a focus on close relationships and less time invested in peripheral relationships (Carstensen, 1992).

In addition, hopelessness in older people may be different to hopelessness seen in younger people, not only due to the idea of the sense of limited time but due to negative ageing stereotypes. In other words, older people may endorse the negative ageing stereotypes which can lead to deterioration in their psychological well-being (Levy, 2003). Laidlaw et al. (2001) give the example of a common viewpoint in

older people is *"you can't teach an old dog new tricks"* (p.161) highlighting the ageist societal attitudes which can exist in older people. Overall, the presence of hopelessness in non-depressed older people may represent a different construct from those older people who are depressed and would warrant further research.

The finding that hopelessness may be a separate construct in the older population highlights the importance for clinicians in continuing to assess for hopelessness with this age group. Hopelessness can be often assumed to be a normal reaction to the challenges of ageing when individuals are exposed to multiple losses. However, this is an assumption which must be disregarded as hopelessness has been found to be a strong predictor of suicidal thoughts with older people with those who have a negative view towards the future more likely to be suicidal (Uncapher et al, 1998). The prevalence of hopelessness has been found to be higher in psychiatric populations where individuals have recurrent depressive episodes. However, it has been shown to exist in the absence of depressive symptomology. Due to the apparent complexity of hopelessness in older people and its potential to have an impact on mortality it should be routinely assessed as part of a clinical interview (Bulik, Carpenter, Kupfer and Frank, 1990).

On a methodological note, future research is required to ascertain norms for older people with and without mental health difficulties (Conaghan and Davidson, 2002). The need for clarification of the BHS norms is highlighted by the observation in this study that although the majority of older people in the non-depressed group achieved BHS scores within the 'normal range', 28.6 per cent of the group were within the

‘mild’ range. It was also observed that the majority of older people in both the depressed and non-depressed group rated the statement “*I cannot imagine what my life will be like in 10 years time*” as true. A possible explanation for this may be that people over the age of 65 may consider this statement to be irrelevant for them. This is made clearer when we look at life expectancy statistics for the United Kingdom which reveal that men aged 65 are expected to live for a further 16.6 years and women aged 65 are expected to live for another 19.4 years (The Office for National Statistics and Government Actuary’s Department, 2005). In this study, the average age of people who participated was 74. Therefore, it is likely that regardless of whether they were depressed or not, some of the individuals who responded ‘true’ to the statement were perhaps realistic in their response, viewing their time as limited as opposed to it being a sign of hopelessness.

4.2 Hypothesis Two

The hypothesis that older people in the depressed group will have smaller support networks in comparison to older people in the non-depressed group was supported. This study found that older people in the depressed group had a significantly lower number of people within their social network when compared to older people within the non-depressed group.

However, an important factor to consider is the effect that depression may have in artificially reducing the number of people that a person may have in their social network. More specifically, individuals who are depressed may withdraw from

activities or find social occasions effortful. This is likely to impact on an individual's network size. It was also important to consider that marital status may be a confounding variable as there were fewer married older people in the depressed group when compared to the non-depressed group. Therefore, it was important to test that marital status did not impact on the size of social network. The finding was non-significant, suggesting that there was no evidence that marital status reduced social network sizes. Therefore, it is likely that the reduction of network size was due to the depressive illness.

However, it is important to note there was no significant difference in self-reported measures of adequacy of social support between the depressed and non-depressed group. This suggests that older people in the depressed group may have fewer people in their social network but are equally satisfied with the level of support the network brings when compared to older people in the non-depressed group. This finding contradicts earlier work by Pagel, Erdly and Becker (1987) who found that dissatisfaction with one's social network was consistently related to depression in older people.

The findings of this study supports previous gerontological literature which shows that it is not the size of network which is important but the quality of social support within the network (Lam and Power, 1991; Bisconti and Bergeman, 1999). This finding would be in keeping with Socioemotional Selectivity Theory (Carstensen, 1992) which suggests that older people will have smaller social networks in comparison with younger people. However, older people are likely to invest heavily

in these relationships with shift towards more positive emotion (Satre, Knight and David, 2006). This may also explain why, in general, there are lower prevalence rates for depression in older people than in younger people (Carstensen et al., 1997). However, this explanation should be treated with caution as extensive research has suggested that depression is an under recognized and under treated disorder in older people (Blanchard, 1996).

4.3 Hypothesis Three

The hypothesis relating to social support suggested that those older people in the depressed group would report lower levels of perceived social support than those in the non-depressed group was not supported. The data suggested that there were no differences between perceived and ideal emotional support when comparing both groups. In addition, there were no differences between perceived and ideal practical support when comparing both groups. This result suggests that older people who participated were equally satisfied with the support they perceived from their social support networks and that depressive symptomology did not impact on individual's perceptions of their available support. This is an interesting finding as one would expect that the nature of depression, specifically, biases in thinking, may impact on an individual's appraisal of their support network. Indeed, the finding of this study contradicts previous studies which suggest that depressive cognitions can have a negative effect on an individual's perception of their support (Sarason, Sarason and Shearin, 1986; Lakey and Dickinson, 1994; Maher, Mora and Leventhal, 2006) and that depression is associated with satisfaction with levels of social support (Oxman,

Berkman, Kasl, Freeman and Barrett, 1992). However, it is important to highlight that this result may have been confounded by individuals who are depressed may be less likely than those who are not depressed may have lower ideal social support ratings which may spuriously lower the actual-ideal differences. This potential discrepancy was not taken into account and may be something to control for when using this measure with a depressed population. In addition, the discrepancy between ideal and actual practical support in the depressed group may miss significance due to potential power issues in relation to the sample size.

In keeping with no difference found between groups in terms of actual and ideal emotional and practical support, the study did not find that older people who had depression viewed their social support as unsatisfactory. This finding is surprising given that a major depressive episode can give rise to depressive cognitions about the self in relation to other people which can subsequently have a direct effect on interpersonal relationships (Maher et al., 2006). A possible explanation to this finding may be that individuals in this study may genuinely perceive their current social support as being adequate and may have stable close relationships with significant others. SST may also account for some of the finding that there were no differences between groups with regards to perceived social support.

According to SST, as people age they limit social interactions to close family and friends and spend less time on peripheral relationships. As a result, older people may report that they are satisfied with their perceived social support (Carstensen, 1992). However, Lansford, Sherman and Antonucci (1998) point out satisfaction with social

support may not be indicative of satisfaction with life thus highlighting the complexity of depression in later life.

4.4 Hypothesis Four

The hypothesis that older people in the depressed group will be less likely to be married when compared to older people in the non-depressed group was supported. There were differences in marital status with a higher proportion of older people in the non-depressed group currently in a marital relationship. In comparison, a higher number of older people in the depressed group were single, divorced or widowed. This is in keeping with previous research which has found that disruptions in close confiding relationships has been found to be linked with a higher risk of depression (Lynch et al., 1999) and that the spousal relationship acts as a buffer against emotional adversity (Vanderhorst and McLaren, 2005).

It was also observed that older people who were widowed in the depressed group when compared to older people who were widowed in the non-depressed group were more recently bereaved. The majority of older people in the depressed group had experienced a spousal bereavement within the past 9 months compared to the majority of older people in the non-depressed group who had experienced a spousal bereavement more than 2 years ago.

A limitation of this study is that it did not assess for the quality of the marital relationship. In hindsight, this may have been an important factor to consider as some

published research suggests that marital disagreement can be a source of stress and a risk factor in depression (Manzoli et al., 2007) and negative consequences for individual's health (Umberson et al., 2006). A large scale study by Mancini and Bonanno (2006) found that marital closeness can act as a protective factor in the face of psychosocial stress and buffers the impact of functional disability. The issue of marital closeness is an important factor, primarily due to the increase in longevity in which married couples face a significant number of years together after retirement. Laidlaw and Baikie (2007) make the point that the longevity of a relationship within this population does not denote the quality of the relationship nor is it associated with intimacy. In addition, Knight (2004) makes the important point regarding the expectation for happiness in a marriage within this cohort, specifically that they view marital relationships without expectations of personal happiness or fulfillment. Knight (2004) reported "*It is not that they expect to be unhappy; they simply do not evaluate marriage in terms of happiness.*" (p.30).

Given the complexity of social relationships there was not enough capacity in this study to investigate this factor in more detail but may be a point for future research, in particular how older people benefit from marital closeness in later-life and specific factors within this relationship which may mitigate psychological distress.

4.5 Strengths and limitations of the study

4.5.1 Strengths of the study

A large number of studies have looked at social relationships in later life (Sarason et al., 1987; Hagerty et al.,1996; Monahan and Hooker, 1997; Bisconti and Bergeman, 1999; Hagerty and Williams, 1999 and Vanderhorst and McLaren, 2005). However, a large percentage of these studies have used samples made up of older people in the community. This study used both a depressed and non-depressed group which was invaluable in providing a comparison in which to examine the findings of the data. An additional strength of the study was that older people in both the depressed and non-depressed group were comparable in terms of age, gender and level of education. Despite these strengths a number of limitations in this study were recognised. These will now be discussed:

4.5.2 Limitations of the study

4.5.2.1 Sample size

The study was undertaken with a small sample of participants which may limit any generalisations regarding the results. In addition, the age ranges of participants were between 65 and 82 years of age which does not allow for findings from this study to be applicable across the life span. The relatively small sample would not allow the opportunity to address other relevant issues such as gender differences in levels of hopelessness and social relationships between the groups. A larger sample, with equal numbers of male and female participants would be required to conduct an analysis of subgroups in relation to hopelessness and social relationships.

4.5.2.2 Statistical power analysis

A power analysis was undertaken to determine the required sample size for this project. Cohen's tables (1992) were utilized and found that to detect a large effect size for a power of 0.8 with an alpha of 0.05, 26 participants were required in each group. Statistical power has been defined as the probability of avoiding a Type II error or the probability of identifying an effect of a certain size if it exists (Baguley, 2004). As the power of a sample increases it is likely that the probability of a Type II error will decrease (Field, 200). Due to insufficient sample size in the depressed group it is likely that there may be insufficient power and arguably the results may be prone to Type II errors. However, despite the shortfall of participants in the depressed group, it is likely that there sufficient power to detect large effect sizes. This is indicated by the significant correlations obtained in the theoretically expected direction for the variables when testing the association of the groups with marital status, GDS scores, BHS scores and size of social network. Furthermore, significant correlations were found between social network size and the depressed group. In addition, Fishers Exact Test was used to take into account the small sample size. Ideally, an equal sample size in both groups would have been required to increase the statistical power and a replication of this study would require equal numbers of participants in each group to achieve a power of 0.8.

4.5.2.3 Data Analysis

As the assumption of normality had been violated, the non-parametric counterpart of the independent t-test, the Mann-Whitney test was the main statistical test use to analyse the data. However, there is an argument that non-parametric tests have less

power than parametric tests (Greene & D'Oliveira, 1982), specifically that by ranking data (as is the method used in non-parametric tests) some of the information regarding the amount of difference between scores may be lost (Field, 2005). Therefore, it may have been useful in terms of data analysis to transform the data to allow for parametric statistics. However, the loss of power in using a non-parametric test is only less powerful on the condition that the assumptions of a parametric test are met (Baguley, 2004). In addition, if a sample is small, then parametric tests can be used only if the variable is normally distributed and it can be very difficult to test this assumption if the sample is small (Field, 2005).

In the event that the sample size was larger, it would not have been appropriate to use non-parametric tests given that in such cases the sample means will follow the normal distribution irrespective of whether the variable is not normally distributed within the population. Therefore, for large samples sizes parametric tests are more sensitive (Green & D'Oliveira, 1982). Non-parametric tests are most appropriate when the sample size is small (Field, 2005). Since this was the case in this study and non-parametric tests were used to analyse the data.

4.5.2.4 Design of the study

This study was of a cross-sectional design which only measures variables at a single point in time with no follow-up. A disadvantage of this design is that it has not been possible to measure changes which may occur over time. Therefore, it was difficult to ascertain whether there is a change in factors, such as the possibility of social network size increasing as older people recover from their depressive episode. This is

a potential area for future research and would require a longitudinal design in order to assess for any changes. Nevertheless, this design was deemed the most appropriate for this research project.

4.5.2.5 Recruitment

Another limitation of this study is the low response rate of potential participants in the depressed group. A possible explanation of this was that individuals within this group had a diagnosis of depression. As a result it may be that they were less motivated to take part in research or had some concerns that participating may have a detrimental impact on their mood, i.e. individuals may assume that answering questions in relation to depression and hopelessness may make them feel more depressed. In addition, several potential participants were excluded due to their depressive illness being caused by an organic aetiology.

4.5.2.6 Measures

As previously discussed, there appears to be some methodological inadequacies of using the BHS with older people. The main criticism of this measure is that although it has robust psychometric properties for use amongst an older adult population, it was developed among adult psychiatric patients and therefore may not describe aspects of hopelessness specific to later life (Heisel, Flett, Duberstein and Lyness, 2005). An alternative to the BHS is the Geriatric Hopelessness Scale (GHS) which was developed by Fry (1984). An advantage of this measure is that it was developed among older people and assesses interpersonal and spiritual domains which are not assessed by the BHS. However, the GHS has been found to have several

psychometric limitations, namely its low internal consistency and its inability to differentiate between older people with mental health difficulties from older people with no mental health difficulties (Hayslip, Lopez and Nation, 1991; Uncapher, 2001 and Heisel et al., 2005). In light of the methodological inadequacies within the GHS, the BHS was used. Heisel et al. (2005) suggest that when using a measurement of hopelessness in later life one should use a measure addressing interpersonal factors. This was achieved by using the Significant Others Scale and self reporting questions on the demographic questionnaire in relation to support network size and self rating of overall support.

This study did not take into account depression and its co-morbidity with physical illnesses such as stroke, cancer, myocardial infarction, diabetes or rheumatoid arthritis in older people as there was insufficient scope within the realms of this study. In addition, the researcher was mindful that another measure may place extra demands on individuals who were currently depressed. Nevertheless, it may have been useful to use a measure such as the World Health Organization Quality of Life – Revised (WHOQOL-Bref) (The WHOQOL Group, 1998). This measure assesses subjective and objective health status and may be an interesting addition to any future replication of this study.

As discussed in detail earlier on in the discussion, with regards to confounding variables, the study did not take into account the possible interrelationships between measures. This highlights the difficulty when researching variables such as depression and social support which are strongly interconnected. Therefore, it can

make it difficult to extrapolate which variable is impacting on the other. Therefore, the measure of perceived social support (SOS) may have been confounded with the measure of depression (GDS) in that items on the SOS may reflect depressive symptoms. For example, an individual may report that they are not satisfied with the amount of support they are given in a relationship but this may be due to depressive symptoms such as loss of interest and social withdrawal. In order to attempt to resolve these uncertainties with regards to social support and depression measures, it would be useful to conduct a longitudinal study in order to look at changes in the perception of social support as an individual recovers from their depressive episode.

4.5.2.7 Confounding Variables

A confounding variable is described as an extraneous variable which should have been experimentally controlled for but was not (Greene and D'Oliveira, 1982). It is argued that failure to take into account a confounding variable may lead to an incorrect assumption that variables are in a causal relationship (Field, 2005). In relation to the study, it may have been that individuals' who were in the depressed group may have reported a smaller social network due to the impact their depressive illness had on their social relationships. This has been found to be a methodological inadequacy in previous studies which have attempted to separate out the two variables (Maher, Mora and Leventhal, 2006; Blazer and Hughes, 1991). In light of this difficulty, it may have been useful to have a self report question asking individuals what their social network size was prior to the onset of their current depressive episode in order to take into account this potentially confounding

variable. In addition a study which incorporates a longitudinal design may reduce the likelihood of the two variables becoming confounded (Blazer and Hughes, 1991).

4.6 Theoretical Implications

The results of this study suggest that as therapists it is crucial that we consider a life span developmental model in order to guide psychological intervention. Knight (2004) proposed a '*contextual cohort-based, maturity specific challenge*' model (p.5) which has been influenced by the gerontology literature. The model argues that by definition older people are more mature than younger people in certain ways, for example, emotional complexity and accumulated interpersonal skills. According to the model, emotionally associated cognitions and meaningful close relationships become increasingly important as individuals age (Munk, 2007). This idea fits well with SST in that both emphasise the change in motivation in later life to maintain smaller social networks with more emotional investment (Satre, Knight and David, 2006).

It is also recognised that there are specific challenges faced by older people such as chronic illness and grieving for others. Satre et al. (2006) argue that these factors as well as an individual's social context, have considerable significance when working with older people in therapy. The authors go on to argue that knowledge of an older person's social circumstances is vital in order to deliver suitable psychotherapeutic interventions.

Both the 'contextual cohort-based, maturity specific challenge' model and SST adopt a lifespan developmental perspective. This links into the influential work of Erik Erikson (1963) who proposed eight psychosocial stages of development across the lifespan. Each stage is categorized by a particular challenge or crisis which needs to be resolved. In older people, the psychological crisis is integrity vs. despair in which individuals evaluate their lives and reflect on accomplished goals or have worries and despair about unreachable goals (Davison and Neale, 1998). Knight (2004) highlights that it is not the case that every individual over the age of 60 may be at this developmental stage. However, the theory does emphasise that an individual's life cycle can be best understood by putting it into context with the individual's social world and how they interact within it (Erikson, 1963).

4.7 Implications for clinical practice

Throughout the discussion, implications for clinical practice have been discussed and shall not be repeated here. However, the findings of this study draws attention to the need for appropriate psychological intervention for older people and the specific challenges they face in later life. Historically, research on psychotherapeutic approaches with older people has been sparse which gives a limited evidence base from which to draw on when compared to the literature with an adult population (Munk, 2007). Nevertheless, a number of studies have proposed empirically validated psychotherapeutic treatments for older people (Gatz, Fisk, Fox, Kaskie and Kasl-Godley, 1998; Scogin, Welsh, Hanson, Stump and Coates, 2005).

In relation to depression, Interpersonal Psychotherapy (IPT) (Markowitz, 1997) has been proposed as a treatment model for older people (Miller, Frank, Cornes, Houck and Reynolds III, 2003). This is not to say that other psychotherapeutic approaches may be useful in helping older people who are depressed. For example, cognitive therapy may be useful in helping older people to identify, challenge and alter maladaptive thoughts and beliefs in relation to their experiences (Munk, 2007). In terms of cognitions, an individual who is depressed may have depressive cognitions which may impact on their interpersonal relationships. For example, an individual who is depressed may be more likely to believe they are being viewed more negatively by the people around them (Maher et al. 2006). However, given that the presented study looked directly at social relationships and depression, the benefit of IPT rather than any other psychotherapeutic approach appears to be compatible for older people within this context, particularly in light of interpersonal difficulties which can arise from the increasing frequency of the death of family and friends and changes within the social role (Karel and Hinrichsen, 2000).

IPT is a time limited psychological intervention which aims to address the interpersonal difficulties experienced by individuals. There is little research published regarding the efficacy of this treatment approach with older people. However, a study by Reynolds, Frank, Perel, Imber, Cornes, Morycz, Mazumdar, Miller, Pollock, Rifai, Stack, George, Houck and Kupher (1992) showed that IPT can significantly decrease the risk of a relapse of depression in older people. Karel and Hinrichsen (2000) reported that IPT is a useful psychotherapeutic approach to use with older people given that they are likely to experience an increase in the death of

family and friends leading to a change in social roles. As individuals age, interpersonal difficulties will be related to grief, loneliness and loss of role (Munk, 2007).

The model of IPT would be in keeping with the premise of SST, specifically, that older people will invest heavily in close relationships to meet their emotional needs. Therefore, interventions which aim to address the interpersonal needs of an individual are crucial particularly in encouraging successful ageing. The development of meaningful supportive interpersonal relationships may help to enable an individual to bring about an optimistic outlook for the future and thus reducing potential distress (Hirsch, Duberstein, Conner, Heisel, Beckman, Franus and Conwell, 2006). Individuals who have low perceived social support may benefit from addressing interpersonal difficulties or taught interpersonal skills (Lynch, et al., 1999).

The findings of this research suggests that as clinicians, emphasis should be placed in helping older people to invest their resources to maintain important relationships and achieve emotional salience within these social ties. In addition, clinicians working with older people should enquire about current levels of hopelessness and recent interpersonal losses as part of their initial interview and be aware of the factors associated with increased suicide risk within this population.

4.8 Future research

Throughout the discussion, several suggestions for future research have been proposed which shall not be repeated here. However, one area which has yet to be mentioned is the impact of bereavement. As part of the present study, individuals were recruited on the basis of having a diagnosis of depression or not being depressed. The amount of individuals who were bereaved made up 39.5 per cent of the overall sample. It is interesting to note that there was a difference between widows/widowers in the groups in relation to time elapsed since the death of their spouse. It was observed that the average time, since the loss of a spouse, which had passed for widows/widowers in the depressed group was 10 months compared to 7 years for widows/widowers in the non-depressed group. This is an interesting finding given that it is estimated that 20 per cent of older people who have been widowed are likely to meet the criteria for major depressive disorder a few months following the death of their spouse and can last more than a year in a third of these circumstances (Sable, Dunn and Zisook, 2002).

Widowhood is a frequent aspect of ageing and the death of a partner can result in a loss of emotional and social support (Stroebe, Zech, Stroebe and Abakoumkin, 2005). Therefore, it may be expected that an individual who has lost a spouse will be required to find alternative sources of support (Pachana, 1999). Research has shown that increased social activity is a means of coping with psychological distress caused by a spousal bereavement (Utz, Carr, Nesse and Wortman, 2002). However, Carstensen (1992) argues that based on the premise of SST, older people who have

been widowed do not take advantage of social activities but rely on established meaningful relationships.

What is evident from the literature is that the psychological distress following a recent loss can lead to loneliness and depression in some older people, particularly those individuals who have small social networks and infrequent opportunities to see important friends and/or family members (Hagerty and Williams, 1999; Adams, Sanders and Auth, 2004; Cacioppo, Hughes, Waite, Hawkley and Thisted, 2006; Heinrich and Gullone, 2006). This is an important area for further research, namely, to investigate social support and social relationships in relation to the impact of bereavement and subsequent psychological well-being. This would be beneficial in order to ascertain whether social support can help to mitigate the effect of bereavement.

4.9 Conclusion

This study aimed to investigate social relationships, depression and hopelessness in older people. The study showed that level of hopelessness was not associated with level of depression. This finding suggests that hopelessness as an individual factor should be considered as a separate factor when clinicians are assessing for depression. In addition, the presence of hopelessness within a non-clinical sample suggests that older people may have a degree of realism in relation to their perception that the future is time-limited.

The findings of this study adds to the theoretical application of SST and is in keeping with the theory's main proposal that older people view their life as time-limited and so manage their social networks based on their need for emotional gains (Carstensen, 1992). The reported findings supports the premise that older people may adapt to the ageing process by focusing on social support from a smaller set of ties which includes family and close friends (Carstensen, 1992).

Despite the reported limitations, the findings from this study highlights the complexity and multifaceted nature of social relationships as people grow older regardless of whether they have or have not mental health difficulties. As clinicians it is vital that we understand the social context and take a life span approach when helping older people to improve the quality of interpersonal relationships and reduce psychological distress.

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APPENDICES

Appendix 1

Demographic Questionnaire

Study Number

Please answer the following:

Age

Gender

Level of Education

1. What is your marital status? *(please circle your response)*

Married/Living with someone Single Divorced Widowed

If divorced or widowed how long for?

2. How many children do you have?

3. How many grandchildren do you have?

4. How big is your social network

(Social network is number of people you meet with on a regular basis, i.e. family, friends, day hospital, activity centre, health professionals)

5. How would you rate your overall social support? *(please circle your response)*

Very good good adequate poor very poor

Thank you for your time

Appendix 2

The Geriatric Depression Scale

30-Item version (GDS-30)

Name: Date:

	Yes	No
Are you basically satisfied with your life?		
Have you dropped many of your activities and interests?		
Do you feel that your life is empty?		
Do you often get bored?		
Are you hopeful about the future?		
Are you bothered by thoughts you can't get out of your head?		
Are you in good spirits most of the time?		
Are you afraid that something bad is going to happen to you?		
Do you feel happy most of the time?		
Do you often feel helpless?		
Do you often get restless and fidgety?		
Do you prefer to stay at home rather than going out and doing new things?		
Do you frequently worry about the future?		
Do you feel you have more problems with memory than most?		
Do you think it is wonderful to be alive now?		
Do you often feel downhearted and blue?		
Do you feel pretty worthless the way you are now?		
Do you worry a lot about the past?		
Do you find life very exciting?		
Is it hard for you to get started on new projects?		
Do you feel full of energy?		
Do you feel that your situation is hopeless?		
Do you think that most people are better off than you are?		
Do you frequently get upset over little things?		
Do you frequently feel like crying?		
Do you have trouble concentrating?		
Do you enjoy getting up in the morning?		
Do you prefer to avoid social gatherings?		
Is it easy for you to make decisions?		
Is your mind as clear as it used to be?		

Scoring: Score 1 for each answer in shaded area.

0 – 10:

11 – 20:

21 – 30:

Not depressed

Mild depression

Severe depression

Appendix 3

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

This questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the **past week including today**, darken the circle with a 'T' indicating TRUE in the column next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' indicating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

- | | | |
|--|-----|-----|
| 1. I look forward to the future with hope and enthusiasm. | (T) | (F) |
| 2. I might as well give up because there is nothing I can do about making things better for myself. | (T) | (F) |
| 3. When things are going badly, I am helped by knowing that they cannot stay that way forever. | (T) | (F) |
| 4. I can't imagine what my life would be like in ten years. | (T) | (F) |
| 5. I have enough time to accomplish the things I want to do. | (T) | (F) |
| 6. In the future, I expect to succeed in what concerns me most. | (T) | (F) |
| 7. My future seems dark to me. | (T) | (F) |
| 8. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person. | (T) | (F) |
| 9. I just can't get the breaks, and there's no reason I will in the future. | (T) | (F) |
| 10. My past experiences have prepared me well for the future. | (T) | (F) |
| 11. All I can see ahead of me is unpleasantness rather than pleasantness. | (T) | (F) |
| 12. I don't expect to get what I really want. | (T) | (F) |
| 13. When I look ahead to the future, I expect that I will be happier than I am now. | (T) | (F) |
| 14. Things just won't work out the way I want them to. | (T) | (F) |
| 15. I have great faith in the future. | (T) | (F) |
| 16. I never get what I want, so it's foolish to want anything. | (T) | (F) |
| 17. It's very unlikely that I will get any real satisfaction in the future. | (T) | (F) |
| 18. The future seems vague and uncertain to me. | (T) | (F) |
| 19. I can look forward to more good times than bad times. | (T) | (F) |
| 20. There's no use in really trying to get anything I want because I probably won't get it. | (T) | (F) |

Appendix 4

SIGNIFICANT OTHERS SCALE (B)



Name:

Date: Record Number:

Instructions

Please list below up to seven people who may be important in the individual's life. Typical relationships include partner, mother, father, child, sibling, close friends, plus keyworker. For each person please circle a number from 1 to 7 to show how well he or she provides the type of help that is listed.

The second part of each question asks you to rate how individuals would like things to be if they were exactly as they hoped for. As before, please put a circle around one number between 1 and 7 to show what the rating is.

Person 1 –		Never	Sometimes					Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty? ..	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 2 –		Never	Sometimes					Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty? ..	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 3 –		Never	Sometimes					Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty? ..	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

PLEASE CIRCLE ONE NUMBER ONLY FOR EACH QUESTION



Person 4 –

	Never		Sometimes			Always	
a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Does he/she give you practical help?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 5 –

a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Does he/she give you practical help?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 6 –

a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Does he/she give you practical help?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 7 –

a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Does he/she give you practical help?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7
a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
b) What rating would your ideal be?	1	2	3	4	5	6	7

PLEASE CIRCLE ONE NUMBER ONLY FOR EACH QUESTION

Power and Champion, 1988. From 'The development of a measure of social support: The Significant Others (SOS)', *British Journal of Clinical Psychology*, 27, 349–58. Reproduced with the kind permission of the authors. This measure is part of *Measures in Health Psychology: A User's Portfolio*, written and compiled by Professor John Man, Dr Stephen Wright and Professor Marie Johnston. Once the invoice has been paid, it may be photocopied **within the purchasing institution only**. Published by The NFER-NELSON Publishing Company Ltd, Darville, 2 Oxford Road East, Windsor, Berkshire SL4 1DF, UK. Code 4920 05 4



Appendix 5

North of Scotland Research Ethics Committee (2)

Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Tel: 01224 558503
Fax: 01224 558609

25 May 2007

Ms Angela J Bowie
Trainee Clinical Psychologist
Department of Clinical Psychology (Older Adult Service)
Block D - Clerkseat Building
Royal Cornhill Hospital
Cornhill Road
ABERDEEN
AB25 2ZH

Dear Ms Bowie

Study title: Social Support and Marital Status as Predictors of Depression and Hopelessness in Older Adults
REC reference: 06/S0802/123
Amendment number: AM01
Amendment date: 10 May 2007

The above amendment was reviewed by the Sub-Committee of the REC comprising the Chair, Committee 2, and Vice-Chair, Committee 1.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation. This also applies to the minor amendment received on 22 May 2007.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Questionnaire	2	10 May 2007
Protocol	2	10 May 2007
Participant Information Sheet	3	10 May 2007

Grampian Local Research Ethics Committee (2)

Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558480
Facsimile: 01224 558609

31 January 2007

Ms Angela J Bowie
Trainee Clinical Psychologist
NHS Grampian
Department of Clinical Psychology (Older Adult Service)
Block D, Clerkseat Building, Royal Cornhill Hospital
Cornhill Road, Aberdeen
AB25 2ZH

Dear Ms Bowie

Full title of study: Social Support and Marital Status as Predictors of
Depression and Hopelessness in Older Adults
REC reference number: 06/S0802/123

Thank you for your letter of 26 January 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out. You are advised to study the conditions carefully, in particular:

Condition 1: Annual Progress Report

Under the Central Office of Research Ethics Committees (COREC) regulations NHS Research Ethics Committees are required to monitor research with a favourable opinion. This is to take the form of an annual progress report which should be submitted to the Grampian Research Ethics Committee 12 months after the date on which the favourable opinion was given. Annual reports should be submitted thereafter until the end of the study.

Points to note:

- The first annual progress report should give the commencement date for the study. This is normally assumed to be the date on which any of the procedures in the protocol are initiated. Should the study not commence within 12 months of approval a written explanation must be provided in the 1st annual progress report.

- Progress reports should be in the format prescribed on the COREC website (www.corec.org.uk/applicants/apply/progress.htm).
- Progress reports must be signed by the Principal Investigator/Chief Investigator.
- Failure to submit a progress report could lead to a suspension of the favourable ethical opinion for the study.
- Please note the Annual Progress Report is a short 3 page form which is extremely easy to complete.

Condition 2: Notification of Study Completion/Termination

Under the Central Office of Research Ethics Committees (COREC) regulations researchers are required to notify the Ethics Committee from which they obtained approval of the conclusion or early termination of a project and to submit a Completion/Termination of Study Report. Researchers should follow the instructions on the COREC website (www.corec.org.uk/applicants/apply/endofproject.htm).

Points to note:

- For most studies the end of a project will be the date of the last visit of the last participant or the completion of any follow-up monitoring and data collection described in the protocol.
- Final analysis of the data and report writing is normally considered to occur after formal declaration of the end of the project.
- A Final Report should be sent to the GREC within 12 months of the end of the project.
- The summary of the final report may be enclosed with the end of study declaration, or sent to the REC subsequently.
- There is no standard format for final reports. As a minimum we should receive details of the end date and information on whether the project achieved its objectives, the main findings and arrangements for publication or dissemination of research, including any feedback to participants.
- Please note the Completion/Termination of Study Report need only be a summary document and should, therefore, be easy to prepare.

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		25 October 2006
Investigator CV		25 October 2006
Protocol	1	25 October 2006
Covering Letter		26 January 2007
Questionnaire: Non-Validated questionnaire	1	25 October 2006
Questionnaire: Validated Questionnaire		

Questionnaire: Significant Others Scale		
Letter of invitation to participant	2	26 January 2007
GP/Consultant Information Sheets	1	25 October 2006
Participant Information Sheet	2	04 January 2007
Invitation to Participate - Sharon Milne	2	26 January 2007
Letter from Donna Wiggins agreeing to identify participants for Ms Bowie		26 January 2007
Signature Pager for Supervisor		25 October 2006
Appointment Letter - Sharon Milne	1	26 January 2007
Appointment Letter - Donna Wiggins	1	26 January 2007

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/S0802/123	Please quote this number on all correspondence
--------------	--

With the Committee's best wishes for the success of this project

Yours sincerely

Appendix 5a

Research and Development

Foresterhill House Annexe
Foresterhill
Aberdeen
AB25 2ZB



Date 09/03/07
Ethics 06/S0802/123
R&D Ref: 2007MH001

Ms Angela Bowie
Dept. of Clinical Psychology
Block D, Clerkseat Building
Royal Cornhill Hospital
Cornhill Road
Aberdeen
AB25 2ZH

Enquiries to	Katy Booth
Extension	54656
Direct Line	01224 554656
Email	

Dear Ms Bowie,

Project title: Social Support and Marital Status as Predictors of Depression and Hopelessness in Older Adults.

Thank you very much for sending all relevant documentation. I am pleased to confirm that the project is now registered with the NHS Grampian Research & Development Office. The project has R & D Management Approval to proceed locally.

Please note that if there are any other researchers taking part in the project that are not named on the original Ethics application, please advise the Ethics Committee in writing and copy the letter to us so that we may amend our records and assess any additional costs.

Wishing you every success with your research

Yours sincerely

Katy Booth
Data Co-ordinator

Appendix 5b

North of Scotland Research Ethics Committee (2)

Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Tel: 01224 558503

Fax: 01224 558609

25 May 2007

Ms Angela J Bowie
Trainee Clinical Psychologist
Department of Clinical Psychology (Older Adult Service)
Block D - Clerkseat Building
Royal Cornhill Hospital
Cornhill Road
ABERDEEN
AB25 2ZH

Dear Ms Bowie

Study title: Social Support and Marital Status as Predictors of
Depression and Hopelessness in Older Adults
REC reference: 06/S0802/123
Amendment number: AM01
Amendment date: 10 May 2007

The above amendment was reviewed by the Sub-Committee of the REC comprising the Chair, Committee 2, and Vice-Chair, Committee 1.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation. This also applies to the minor amendment received on 22 May 2007.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Questionnaire	2	10 May 2007
Protocol	2	10 May 2007
Participant Information Sheet	3	10 May 2007

Document	Version	Date
Participant Consent Form: Group A	3	10 May 2007
Notice of Substantial Amendment (non-CTIMPs)	3.1	10 May 2007
Letter of invitation to participant	2	10 May 2007

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/S0802/123:

Please quote this number on all correspondence

Yours sincerely

Carol Irvine

Mrs Carol Irvine
Acting Co-ordinator

Appendix 6

INFORMATION SHEET FOR PARTICIPANTS

Study Title: Factors Associated with Late Life Depression

Invitation to take part in research project

You are being invited to take part in a research project to try and find out more why some older adults become depressed. Before you decide to take part in the research, it is important to firstly understand why the research is being carried out and what it will involve from you. Please read this information sheet carefully.

Why are we doing this research? Why is it important?

The purpose of the study is to develop a greater understanding of the factors associated with depression in older adults in order to inform treatment and management of this difficulty in the over 65 population. By comparing individuals who are depressed and those who are not we hope to find out some of the differences between the two groups. We hope that finding out more about the reasons why some older adults are depressed will lead to better help being available for those older adults.

What exactly is the research trying to find out?

The research aims to investigate whether depression and/or hopelessness in older adults is related to social support and/or marital status.

Who is doing the research?

The research is being carried out by Ms Angela Bowie, Trainee Clinical Psychologist at the Department of Clinical Psychology (Older Adults Service), as part of her qualification of Doctorate in Clinical Psychology at the University of Edinburgh. Dr Katharine Morris, Chartered Clinical Psychologist at the Department of Clinical Psychology (Older Adults Service) and Dr Ken Laidlaw, Consultant Clinical psychologist in NHS Lothian and Senior Lecturer at the University of Edinburgh will oversee the research.

Why have I been asked to take part?

You have been asked to take part because you are between the ages of 65 and 80 years of age. You were chosen as a potential participant as you currently attend either the Day Hospital or Activity Centre or are seen by either a Clinical Psychologist or Community Psychiatric Nurse (CPN). Around 60 other people will be involved in this study.

Do I have to take part?

No, it is completely up to you whether or not you choose to take part. You can stop taking part at any time without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen if I do take part?

The research will take place between November 2006 and August 2007. You will be asked to complete four separate questionnaires. These questionnaires should take no longer than 30 minutes to complete. The researcher will offer you a time to be seen either at Kildrummy Day Hospital, at your home or at Broomhill Activity Centre. This will be a one-off appointment.

Will taking part in this research project be kept confidential? Who will see what I put in the questionnaires?

The information you give in your questionnaire will remain completely confidential. No-one but the researchers will see it. However, in the event that an individual disclose depressive symptoms, suicidal ideation or if the questionnaires indicate significant levels of depression and they are NOT currently receiving help/advise from a health care professional regarding this they would be strongly advised to consult their GP. If any individual currently receiving help indicated any of the above they will be informed I have a duty to inform the Day Hospital manager and Consultant in charge of their care. For those who do not attend Kildrummy Day Hospital I have a duty to inform the individuals Clinical Psychologist, Community Psychiatric Nurse and/or Consultant Psychiatrist in charge of their care.

What are the potential benefits of taking part?

There are no individual benefits for taking part in the study. However, the information that we get may help older adults with depression in the future.

Who has reviewed the study?

Before any research goes ahead, it has to be checked by the NHS Grampian Ethics Committee.

What if something goes wrong?

All participants will be informed that they have the right to withdraw at anytime or raise any concerns before, during or after participation. Should you become distressed as a result of completing the questionnaires, support will be given by the chief investigator. If completing the questionnaires raises important issues that you feel you need help with, we can put you in touch with appropriate sources of help.

What will happen to the results of the research study?

The study will be written up as part of Angela Bowie's Doctorate in Clinical Psychology at the University of Edinburgh. The results will be submitted for publication in a psychology journal.

Contact Details

If you have any questions please feel free to contact the researchers who will be happy to answer any other questions you may have.

Angela Bowie
Department of Clinical Psychology
Block D
Fraser Ward Corridor
Clerkseat Building
Royal Cornhill Hospital
Aberdeen
AB25 2ZH

Dr Katharine Morris
Department of Clinical Psychology
Block D
Fraser Ward Corridor
Clerkseat Building
Royal Cornhill Hospital
Aberdeen
AB25 2ZH

Telephone: (01224) 557497

Telephone: (01224) 557497

Thank you for taking the time to read this and considering taking part.

Appendix 7

Date
Our Ref AB

Enquiries to Angela Bowie
Extension 57497
Direct Line 01224 557497
Email

Dear Sir/Madam

Invitation to Participate in Research

You have been given this information by either Mrs Donna Wiggins (Day Hospital Manager), your Clinical Psychologist or Community Psychiatric Nurse (CPN) who you already know. I am a Trainee Clinical Psychologist employed by NHS Grampian and seconded to the University of Edinburgh. As part of my qualification, I am required to undertake a research project and would appreciate your participation in my project.

I have attached a copy of an information sheet detailing the nature of the study. If you have any questions or queries, I would be happy to respond. If you are happy to take part in the proposed study, please could you give your name to Mrs Donna Wiggins or your Clinical Psychologist or CPN who will contact me and I will arrange a time and date to meet with you. Alternatively, you can contact me directly to arrange a time and date to meet with you.

Thank you very much for your time.

Yours Sincerely

Angela Bowie
Trainee Clinical Psychologist

Appendix 7a

Date

Our Ref AB

Enquiries to Angela Bowie
Extension 57497
Direct Line 01224 557497
Email

Dear Sir/Madam

Invitation to Participate in Research

You have been given this information by Ms Sharon Milne (Activity Centre Manager). I am a Trainee Clinical Psychologist employed by NHS Grampian and seconded to the University of Edinburgh. As part of my qualification, I am required to undertake a research project and would appreciate your participation in my project.

I have attached a copy of an information sheet detailing the nature of the study. If you have any questions or queries, I would be happy to respond. If you are happy to take part in the proposed study, please could you give your name to Ms Sharon Milne who will contact me and I will arrange a time and date to meet with you at the Activity Centre Alternatively, you can contact me directly to arrange a time and date to meet with you.

Thank you very much for your time.

Yours Sincerely

Angela Bowie
Trainee Clinical Psychologist

Appendix 8

**Department of Clinical
Psychology**

Older Adults Service
Block D
Royal Cornhill Hospital
Cornhill Road
ABERDEEN AB25 2ZH
Telephone: 01224 55749

Identification Number:

CONSENT FORM (Group A)

Study: Depression in Later Life
Main Researchers: Ms Angela Bowie (Trainee Clinical Psychologist)
Dr Katharine Morris (Chartered Clinical Psychologist)

Please Initial Box

1. I confirm I have read about the study and
that I have understood the participant information sheet. ☐
2. I have had the opportunity to consider the information
and have been given the opportunity to contact Ms
Angela Bowie with any questions I may have. ☐
3. I have asked all the questions that I want and had them
answered. ☐
4. I understand that I do not have to take part in this study
and can withdraw at anytime without giving a reason. ☐
5. I understand that should I express suicidal ideation the Day Hospital
Manager, Consultant Psychiatrist and/or Clinical Psychologist will be informed. ☐
6. I consent to Ms Angela Bowie viewing my psychiatric file for the
purpose of the study. ☐
7. I am happy to take part in the study. ☐

Your Name:

Your Signature:

Date:

Appendix 8a

Identification Number:

CONSENT FORM (Group B)

Study: Depression in Later Life
Main Researchers: Ms Angela Bowie (Trainee Clinical Psychologist)
Dr Katharine Morris (Chartered Clinical Psychologist)

Please Initial Box

- | | |
|--|--------------------------|
| 1. I confirm I have read about the study and that I have understood the participant information sheet. | <input type="checkbox"/> |
| 2. I have had the opportunity to consider the information and have been given the opportunity to contact Ms Angela Bowie with any questions I may have. | <input type="checkbox"/> |
| 3. I have asked all the questions that I want and had them answered. | <input type="checkbox"/> |
| 4. I understand that I do not have to take part in this study and can withdraw at anytime without giving a reason. | <input type="checkbox"/> |
| 5. I understand should I disclose depressive symptoms or score highly on depression questionnaires I will be advised to seek appropriate help from my GP | <input type="checkbox"/> |
| 6. I am happy to take part in the study. | <input type="checkbox"/> |

Your Name:

Your Signature:

Date: